Meaningful Use Workgroup
Draft Transcript
September 22, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody. Welcome to the Meaningful Use Workgroup. This is a public meeting, and this is also a federal advisory committee, which means there will be opportunity at the end of the call or the end of the meeting for the public to make comments. There will be a transcript of this meeting on the ONC Web site. Just a reminder for workgroup members to please identify yourselves when speaking for attribution.

We'll go around the table now and introduce members beginning on my right with Josh Seidman.

Josh Seidman – ONC
Josh Seidman, ONC.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
George Hripcsak, Columbia University.

David Lansky – Pacific Business Group on Health – President & CEO
David Lansky, Pacific Business Group on Health.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Paul Tang, Palo Alto Medical Foundation.

Deven McGraw – Center for Democracy & Technology – Director
Deven McGraw, Center for Democracy and Technology.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Art Davidson, Denver Public Health, Denver Health.

Judy Sparrow – Office of the National Coordinator – Executive Director
On the phone, I believe we have Neil Calman. Neil, are you there?

Neil Calman – Institute for Family Health – President & Cofounder
Yes, I am. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Anybody else on the telephone? With that, I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks to the members and the members on the phone for joining us on this important day, as we set our sights towards stage two and stage three. To remind ourselves of the purpose of the meaningful use program, which is to increase the adoption and effective use of what we think is an essential, enabling tool to measuring and continuously improving our outcomes, our health outcomes for the country. Reminding ourselves again that this is not intended to be a comprehensive certification program.

We're targeting specific functionality and measures that would facilitate getting us to the next level. So we also are not setting the nation's health priorities. We need to constantly balance, as we did in stage one, the sense of urgency if we need to get these systems up and running and talking to each other as quickly as possible, yet knowing that most of the country isn't there yet. In particular, we paid special

attention to the smaller practices, the smaller hospitals, critical access hospitals, and rural providers. We're trying to raise the tide, but at the same time not sink all the boats.

Let's review a little bit of the history of how we got here. We had the meaningful use stage one criteria, which, as we all know, we put together in about six weeks with most of the work being done in the last couple weeks, so that was quite a sprint. For this next stage, stage two and three, we've had more time to systematically sort of prepare for drafting the next set of recommendations. So you'll recall that we had a series of hearings covering all of the four categories. We heard from specialists. We heard from the smaller providers, whether they're physician practices or hospitals. We had a patient engagement panel. We had one on care coordination and we had one on public and population health.

David Lansky – Pacific Business Group on Health – President & CEO
Disparities.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was just going to mention, we just had a panel on disparities or at least testimony on disparities just the last meeting. All along the way, of course, we've heard from the public, so that's been a continuous stream of input.

At this point, today our goal is to start working on stage two and three. Ideally, we would get our first draft out by the end of the day. I think that might be pressing it a bit, so we've scheduled another call, a four-hour call. In other words, we'll have more time together before we have to present on the 20th to the full policy committee.

Speaking of which, the timeline we set out for ourselves today is our face-to-face, all day meeting to work on our draft recommendations. We're taking into account as input obviously the CMS final rule, the summary and recommendations we have from our public hearings. We also have a report known as the Gretzky Report, which is a report from NQF. Well, NQF assembled a group to look at, in the Gretzky style, where the puck is going and trying to target quality measures that are defined with clinical data out of an EHR. So that's where the puck is going.

There is a separate workgroup that, as you know, David Blumenthal heads up, so that workgroup is going to be dedicated to looking specifically at quality measures particularly for the stage two going towards stage three. So we're not going to spend a whole lot of time on that, but if there are things that come to mind, we can note that. Then we'll have public input at the end of this meeting, of course.

We're going to present our draft set of recommendations at the October 20th full committee meeting, get input from the reset of the committee, and then digest all of that and put out an RFI in the November/December timeframe. That'll be yet another time when the full public can provide formal comment on our draft recommendations.

At the beginning of next year, we will start getting indication of how many people and how many organizations are already submitting applications to receive their incentives for stage one. The first opportunity people will have to do that is in April, following a 90-day reporting period. The first payment would come out in May according to CMS. But the beginning of the second quarter, we should have some information on the kinds of organizations that are prepared to make their submissions and get some sense of the market. We wanted to use that information as part of the mix of input that goes into drafting our recommendations for stage two and stage three. We're trying to get information out as quickly as possible, but we don't want to ignore feedback from the first stage.

Only propose a product today and get your feedback on that, so one way to approach it would be to take what we have as stage one, and then to sort of increment on that and go to stage two. One of the goals we had, we didn't have the luxury of time the last time around, is to try to set sort of a roadmap or a glide path is what we called it last time. To the extent that we can set the goals of where we're heading towards and then sort of set the stages of getting there, that I think would serve everybody: the provider community, the vendor community better. I wonder if we would operate in that way today, that is, work on

stage three sort of objectives and measures, and then fill in the gap of what's along the way to stage three.

Let me pause a little bit and see if that's an appropriate strategy …. Comments …?

Deven McGraw – Center for Democracy & Technology – Director
I have a question, Paul. I like the idea of thinking about the endpoint where we want to be and then backing up to it. But it might be easier to do that if we think about the endpoints in a broader way versus in the specific way that we had to craft stage one. Can that be part of the process?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, absolutely.

Deven McGraw – Center for Democracy & Technology – Director
So for example, you might have—as a stage three goal—patients and physicians actively exchanging information as opposed to sort of parsing that out ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Exactly, and then we'll sort of work backwards in filling in the gaps. But the first principle, let's work on stage three, and then get a midpoint rather than trying to increment from where we are. It sounds like that's a fair approach.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I would just say I think I might look at goals differently. I like that approach, but as you know, I've been suggesting that we think about health improvement goals at the same time. So I think there are some outcome process goals around better coordination, for example, that makes sense. But I think I wouldn't totally focus, as Deven is saying, on just the specific objectives or measures, rather, and functions and features in stage three, but rather, think about what are we trying to achieve and then back into what did we learn from all of the hearings this year about what we think is possible and really needed to achieve that goal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'll review some of the criteria we used last time around and some of the ones that have come up in hearings since. We all sort of agreed on this word parsimonious, so rather than it's the sort of 500 versus the exemplar approach, and we had worked towards the exemplar, the fewer measures that people would have to drill down on, but they would be very illustrative of the kinds of things we're after. That we wanted to, as much as possible, use evidence-based outcomes where there's a tie between the outcome, even if it's a process or intermediate outcome, and the HIT systems because we're not just measuring health or healthcare process or health outcomes. The purpose of this is how do we use this as an enabling tool to achieve those, so that linkage is important.

That we try to, as much as possible, to reduce the burden on individual organizations to reduce their reporting burden on individual organizations to try to use coded data as much as possible. So they tried to do that in the final rule for stage one, for example. That we want to make sure that people are capturing this information as a byproduct of care, not having a separate process to fulfill these requirements, so that's sort of fitting the workflow of the clinicians and the patients.

That if we try as much as possible to apply, to have these things apply to as broad a spectrum of providers as possible. Once we start getting into, well, it works for this group, but not that group, then the set of measures and objectives expands very quickly. That's sort of the kind of things we considered when we put together stage one and the kind of criteria that have been used for a lot of the program in the HIT incentive program throughout this process.

There's been a couple or maybe three different worksheets, so thanks to Josh and Adam and Judy, we have a very nice template that sort of summarizes where the final rule is, what we had from our public hearing, some of the recommendations, and the placeholders we set for ourselves in the stage one, sort

of the overall framework. Then I added some things just because it's easier to critique things than to come up with things de novo, so I added some things in a column, and George added to it, and then Christine sent around another matrix. So we'll have plenty to start with that has no barring on where we end up with, but it's just easier to start with something.

I think, what we could do probably is we'll take these at a category at a time. As I said, ideally we'd finish all the categories. That may be more ambitious than we have the time. We'll see how things go. But we'll first start with category one, which is the improved quality, safety, and efficiency, and reduce disparities. It's going to be hard because the matrix has a lot of columns, so it's going to be hard to see everything in one, but let me open up the floor for comments on, if you want to, as you suggested, look at general goal areas. We could certainly do that, or we could work on some of the starting points, which is the final rule in stage one, and see how that might progress, and then make sure we cover all the ground in terms of the goals we want to achieve by 2015.

David Lansky – Pacific Business Group on Health – President & CEO
…just get oriented to the packet, Paul. We've got three or so versions of this at the beginning of the packet. I just wondered, are they different or are they just different slices of the same pie?

Josh Seidman – ONC
The one with the blue column on the right has Paul's comments. That's Paul's stage three.

David Lansky – Pacific Business Group on Health – President & CEO
So we ignore that one?

Josh Seidman – ONC
Yes. That's the one. Avoid that one at all costs. It's stage three targets of the files that you got, you got additional files. But the one I think we'll base on is that one.

David Lansky – Pacific Business Group on Health – President & CEO
All right. So the one with the blue ink on the right that has Paul's stage three targets proposed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
Gives us something to kind of ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And rather than call it target, it's just the starting point.

David Lansky – Pacific Business Group on Health – President & CEO
Sure. That's good. It gives us a starting point, so we don't need to look at the first two flavors at the moment?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I guess they're just tools there.

David Lansky – Pacific Business Group on Health – President & CEO
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
The column that says HIT Policy Committee August '09 stage two or stage one not included, that comes from our recommendations.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. So we know that some of the column, some of the first column items are menu sets, and we assume they become core. Is that correct?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

David Lansky – Pacific Business Group on Health – President & CEO
Just for everyone's benefit, I just saw this, but the color version at the top of the packet has a little more printed detail than the version with Paul's comments, so if you only look at Paul's version, you will be … all this text is not ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's interesting.

David Lansky – Pacific Business Group on Health – President & CEO
…formatting problem.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
So just be aware of that as you go through.

Neil Calman – Institute for Family Health – President & Cofounder
Judy, was that e-mailed out?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, the last one that I e-mailed out late, I think it was yesterday, it was the one with Paul's comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The one I had started with was the one that was without color. That's what I thought I started with, and somehow those, the public … recommendations.

M
What ….

W
Yes.

M
It's the detailed ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And so ….

M
We got cut off ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes … so the ….

Josh Seidman – ONC
…got e-mailed. And the one on the screen has everything.

David Lansky – Pacific Business Group on Health – President & CEO
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But the printout ….

David Lansky – Pacific Business Group on Health – President & CEO
The printout may be missing something.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The one on the screen does have everything?

Josh Seidman – ONC
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, if I could comment about the first bucket. For me at least, it might be helpful to take the tag words—quality, safety, efficiency, and disparities—and treat them as separate questions conceptually, especially to the point of setting our 2015 goals. Then these other, the individual measures will fall under one or more of those four headings.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are you proposing that we actually divvy it up to quality, safety, efficiency, and disparities?

David Lansky – Pacific Business Group on Health – President & CEO
Well, at least conceptually that I think we do need to address all four of those to some degree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What if we had a separate checklist, and we could make sure that these things got covered at the end, because otherwise then we would start having duplicates in all four categories, I would think.

Deven McGraw – Center for Democracy & Technology – Director
I want to give a general reaction and put something out there, and I'm looking at the chart with Paul's notes that essentially take the percentages and ratchet them up higher.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And add to them.

Deven McGraw – Center for Democracy & Technology – Director
And add to them, right. Okay. Maybe we should have a chance to look at this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. As I hear people ….

Deven McGraw – Center for Democracy & Technology – Director
And skimming down this, I was like, you know, that's an approach that feels—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Deven McGraw – Center for Democracy & Technology – Director
It's certainly consistent with where we started.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Deven McGraw – Center for Democracy & Technology – Director
But doesn't to me seem to get us to, I think, where we want to be, which is ultimately with outcomes versus just thinking of do you have all the data in the system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Maybe it's useful to go through.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
At one point we do want to not leave any dangling participles, so that's one approach. We can make sure we do that. We can make sure then we do the checklist that David proposed. Let's make sure we hit safety, quality, efficiency, and health disparities, and then make sure we have the overall goals, and we haven't lost that. So it's almost like coming at it with three or four different filters.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But we certainly don't want to leave the dangling participle.

Deven McGraw – Center for Democracy & Technology – Director
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was one of the things I wanted to start out with.

Christine Bechtel – National Partnership for Women & Families – VP
I think, to Deven's endpoint, I know I'm killing the audio, guys. So our glide path, remember the slide with the arrows and the three points?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Christine Bechtel – National Partnership for Women & Families – VP
The third point was—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Improving outcomes. Right.

Christine Bechtel – National Partnership for Women & Families – VP
So should we start there? I think that's part of what you're suggesting, which is if you start with stage three, you have to start under, okay, how is it that IT systems are going to help actually improve outcomes? Then you back into, how is it that IT systems are going to be—I think the second point is data sharing basically, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Christine Bechtel – National Partnership for Women & Families – VP
I'm sorry?

Deven McGraw – Center for Democracy & Technology – Director
Advanced processes.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, advanced processes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, the first one ….

Christine Bechtel – National Partnership for Women & Families – VP
Some of these, I think, to Deven's point, aren't advanced processes, but that we could be parsimonious if we started with outcomes and advanced processes, you would necessarily have to do some of these without having to have a measure around it if we back in that way.

David Lansky – Pacific Business Group on Health – President & CEO
For example, we may almost discard some of the documentation up to date.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
But 2015, we don't need to check whether your medication list is up to date if we're measuring some other medication related outcome.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

David Lansky – Pacific Business Group on Health – President & CEO
This is indirectly required. It's instrumental to the outcome goal.

Christine Bechtel – National Partnership for Women & Families – VP
Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I hear what you're saying. I think there'll always be a need to have a complete problem list and a complete medication and a complete allergy list, and that's one of the few structural. Indeed, there are only a few structural measures where it's 80% of stage one, and we'd hopefully move it very close to 100%. But some of those things—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We don't want to create an incentive for someone who thinks they can achieve the outcome without it to skip it because they started late. In other words, adopt later so I don't have to do medication lists because I hate them, and then achieve meaningful use without medication lists because we took off the list, and they joined in on stage three or something.

Christine Bechtel – National Partnership for Women & Families – VP
I agree with that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So I agree with David's philosophy, but now that we created some of these things, I think we're kind of stuck with those. The structural ones that are there, because they're inherent in the other stuff, I don't think we'll be hurting anyone. I guess we'll be wasting a little bit of time in having them have to measure it. I guess that's the downside.

Christine Bechtel – National Partnership for Women & Families – VP

But I think the conversation gets easier when we get specific because I agree with both you and David, and I think we want to make sure we're monitoring unintended outcomes, but there are, I would hope, some areas where at least in stage three we could reduce reporting burden and be parsimonious and meet some of our other kind of principles. But there are some places where particularly, I think, the clinicians among us need to flag. You can actually do this without an up to date med list, so we need to keep med lists in. But I think, as a principle matter, I think we should try to take some of that out where we can where it doesn't create an unintended consequence. But I think to, Paul, your approach, it does require starting with, if we think about orders—CPOE orders by stage three—what's the outcome we're trying to achieve by requiring, in stage one, or laying that groundwork around 30% of all orders. What's the outcome we're trying to achieve, and then backing into what's a stage three, what's a stage two criteria for that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
As this discussion evolves, I think it's pointing out there's sort of two categories of end stages, and one is the outcomes, and another is sort of structural, at least where the structure is so central to the care process, really, the integrity of the record. I think what George and I are saying is up to date problems, meds, allergies are one of those essential, structural things that are important to every record, so really still developing import to every record, and that it's not easy. So that work in doing that versus an exemplar saying do you have the machinery to have decision support, for example. That you can't possibly test 1,000 rules, but you'd want to be able to test that you have the machinery in place and that your culture knows how to take advantage of it.

Christine Bechtel – National Partnership for Women & Families – VP
Right. So one approach might be to go sort of line-by-line and say, okay, for drug/drug interactions and allergy checks, what are we trying to achieve? Well, it turns out to be we're trying to detect and overt ADE. Okay. Fine. Let's then back into a stage three measure, which would be the percent of drug interactions detected, and then what does that mean for stage two? Then the next line is e-prescribing. Well, that plays into the same goal, so we can search group things by goals and figure out what we need and don't.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's a good compromise, Christine, in the sense of let's look at line-by-line, so we don't have the dangling participle, but let's look. What are we trying to accomplish? What did we even try to accomplish in stage one, go all the way there, and then back our way into stage three?

Christine Bechtel – National Partnership for Women & Families – VP
Right, and what does it mean for outcomes stage three, and what does it mean for data sharing stage two or advanced processes, I guess.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is that fair?

David Lansky – Pacific Business Group on Health – President & CEO
I guess … discussion, a later step is to go back through and push off any measure, which is one of the structural documentation measures where we think the outcome measure permits us to do so. If we could make the tree a little bit bigger than necessary now and prune it later.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Also parsimony, that's for sure. We're starting out with one of the biggest and probably the most important, which is the computerized physician order entry. To remind ourselves, we had thought about it as CPOE for all orders, and for a number of reasons it appears in the final rule as CPOE for Rx only and at 30%. Going back to what we thought about is CPOE is one of the essential functions of a comprehensive EHR because that is where the system is providing helpful advice, whether it's reminders, alerts, other kinds of decision support at the point where providers, order providers are making decisions on patient care, so they're extraordinarily important, and that's been well proven in the literature.

Looking at the outcome, it's really influencing the ordering behavior of those who are licensed to write orders, decision support, so backing into a stage three, ideally we would want all of the decisions to have that support. And the only thing against 100% is there just, you just can't capture everything, and so picking some arbitrary number. That's the approach for getting the 90% of all orders. How does that resonate with folks?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think that seems reasonable. On line seven, there is a longitudinal/delta. I don't know what that—it's the line before CPOE—do you know what that—?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I didn't know what that was either. Maybe Josh.

Josh Seidman – ONC
Sure. What we were trying to do was just show some of the potential, the work of the quality measures workgroup that Paul referenced at the beginning is beginning, and it is going to be working concurrently on trying to fill in gaps on measures. And so some of the measures, in this case this is in the general domain of quality, safety, efficiency rather than related to a specific objective. In some cases, there are some things related to specific objectives, just some ideas of some of the clinical quality measures that have already come up in the discussion of the quality measures workgroup.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Thank you. But I do think it seems reasonable that if we're expecting this to happen by 2015, we've got to get as much as possible mediated through order entry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so it sounds like there's agreement on one that is all orders, as much as possible, so that's the 90% versus 100%. What would we put as an intermediate step for stage two then?

Neil Calman – Institute for Family Health – President & Cofounder
Yes. I guess, if the quality measures workgroup, are they going to be also discussing percentages … measures? If so, then maybe we should just be talking about what the measure is, but not to argue about whether it's 90% or 60% or 70% at this point.

Josh Seidman – ONC
Not on the functionality measures.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. They're the CQM, the clinical quality measures. So, in that area, they are core measures, the additional measures, that grouping.

Christine Bechtel – National Partnership for Women & Families – VP
So blood pressure under control for people with diabetes as opposed to….

Neil Calman – Institute for Family Health – President & Cofounder
So they're no going to be dealing with these measures at all.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct.

Deven McGraw – Center for Democracy & Technology – Director
No.

Neil Calman – Institute for Family Health – President & Cofounder
Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, isn't there a signal for 60%, which is not in our …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point. That's a good point. Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So they've already ….

Christine Bechtel – National Partnership for Women & Families – VP
Sixty percent medication ….

David Lansky – Pacific Business Group on Health – President & CEO
For medications only?

Christine Bechtel – National Partnership for Women & Families – VP
For medications.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So they signaled 60% medication orders and, I think, so we can independently say, well, is medication enough? If not, then what would be the percent we would incorporate? Now this is totally a first draft.

Deven McGraw – Center for Democracy & Technology – Director
I'll say that medication orders isn't ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Not enough. Okay.

Neil Calman – Institute for Family Health – President & Cofounder
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we would be agreeing with ourselves, I think.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Okay. So if that's true, where would you put the threshold, just as a placeholder?

Deven McGraw – Center for Democracy & Technology – Director
Well, it's going to expand it to a greater number of orders, and rather than tinkering with the percentage, maybe we expand it horizontally before we up it vertically.

Christine Bechtel – National Partnership for Women & Families – VP
So you're saying 30% of meds, lab, etc.

Deven McGraw – Center for Democracy & Technology – Director
Yes, just as a thought.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm not discouraging the direction, but a comment I'm thinking about what the measure is. CPOE is part of the close with medication process. It's … to reduce the medication errors. So I'm struggling a little bit with how you … because when people implement it, they watch the whole process, and they look where there's gaps, and the intent is to bring evidence to the point of care, so CPOE seems to have other outcomes it's accomplishing … like you want to put evidence-based order sets in and all that kind of stuff. But it seems like it's a broader, long-term objective than simply 90% of orders.

I don't think that's going to get us to the intent of what you really want to accomplish. I don't know how we frame that because I'm struggling with what's the real measure you're trying to do, plus the structural measure. But I don't think the structural measure is going to get us to what you—people … what we're finding is if the customers understand the intent, they do a lot better than just seeing the prescriptive item on the list.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we've been saying both of those things.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I know, so ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're just going one sort of perspective at a time, and then make sure we triangulate, and all of those are accomplished.

Christine Bechtel – National Partnership for Women & Families – VP
But the intent broadly is better quality, safety, and efficiency and reducing disparities, and we want to get to that through decision support. Part of the way to get to that is CPOE. Is that what you mean, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's CPOE plus other processes.

Christine Bechtel – National Partnership for Women & Families – VP
For sure.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I mean, there's a lot of work going on in the whole how am I reducing errors and get down to zero percent and all that kind of stuff.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
So there's a lot of work that ….

Christine Bechtel – National Partnership for Women & Families – VP
But does that address your question if we articulate that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, let me just add that ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm not sure there should not be an error measure in some places here, not a drug/drug interaction check. That's just one of the processes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's really the error that we want to understand or some measure around that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, I think so. So when we come back with the outcomes perspective, we'll make ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's not the big one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's an intermediate measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. And we do have another e-Rx. There are other line items that address other structures of the process and outcomes that you were talking about.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. We're at 30% of all orders as our first path? I think we're going to revisit this and keep checking ourselves.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But this is just something to have on the ….

Josh Seidman – ONC
So I wrote down so far that the clinical motivation, because since were starting with the clinical motivation for this is decision support and improved ordering processes. That's that last column. I'm just adding that as we go so we can chart back.

Deven McGraw – Center for Democracy & Technology – Director
That's great.

Josh Seidman – ONC
Then I put for the actual metric would be CPOE for 60% of medication orders and 30% of all other orders. Is that what you intended, or just 30% across the board?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What Deven said was 30% across the board. How do people feel with what's written there?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think it's a good idea.

Deven McGraw – Center for Democracy & Technology – Director
I do too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's fine. Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The issue you can't implement that way.

Art Davidson – Public Health Informatics at Denver Public Health – Director
You don't ….

Deven McGraw – Center for Democracy & Technology – Director
But you've already implemented 30% of drug orders.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Actually, most will have to implement everything because you can't break that ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
At 30%, so then they'll go to 60%.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right. You have to ….

Neil Calman – Institute for Family Health – President & Cofounder
Yes ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It breaks the workflow. It creates safety problems.

Christine Bechtel – National Partnership for Women & Families – VP
Right. Agreed.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Neil Calman – Institute for Family Health – President & Cofounder
There's a real … here about when you partially implement something, you don't actually create more of a probability of errors and mistakes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, one of the original, and we've discussed that in stage one, Neil. What we thought about in terms of the 10 or 30 or whatever it is, is that it was unit-by-unit was one of the approaches people could take. You're absolutely right. We're not saying you only have to get half your orders in there, and the other half can be on paper. That would be completely disruptive. But what we thought originally with the 10% that was our first recommendation was they would start in certain units.

Deven McGraw – Center for Democracy & Technology – Director
Then the alternative would be, say, 50% of drugs, labs, and something else, and then you add the rest of the clinical processes by stage three. Is that what …?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes ….

Neil Calman – Institute for Family Health – President & Cofounder
But stage two, we're not expecting to have two units doing radiology orders electronically. By stage three, we're expecting these things to be fully implemented, right?

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. The only reason it wasn't 100% is let's say you have reference lab stuff, and the only way that you can send that is by paper. There are certain exceptions that make it not 100%.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
One positive because of the short timeframe to what you were talking about, vendors have to be certified for labs and rads right now, so they are going in with certified products, so people could get started. So if we signal at least labs and rads right now, that would be, at some level we can debate that, but I think that would be really positive because people will move forward.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
There's one thing that CMS was addressing was when you say all orders, what does that include? Does that include referrals? Is that an order or not an order? By being specific, that made it easier to measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But Charlene's point ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That would go along with Charlene ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene's point is good too because we already have something in place. We're just cranking it up. It's a lot easier.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
And effectively right now what we have is 30% of med and zero percent of lab and radiology, so we have a two-tier system with 30% and zero. The question is, do you want to go up and level it, or do you want to go up and add 30% to both sides? We could change it to 60% and 30% of lab and rad, or we could do 30% across the board or 60% across the board.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But the actuality, when you say 60%, it's got to be 60% across the board.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's like, it's because you don't want to break that workflow because you'll create an error.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think 60 across the board is the most consistent with workflow. It's already built into stage one, i.e. they said they're going to 60% for meds. That'll be consistent. And to George's point, are we …?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We'll get some pushback.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…radiology, lab, and ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Sixty percent med, lab, and rad orders.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How is that?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Good.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
May I make one other comment? I don't' know I we want to weigh in on this, and we don't have to weigh in on this today, but there's tremendous confusion about who can enter orders. It says licensed professionals, but there are many interpretations of this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're not ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We argued that before.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There's a lot of CMS effort going into interpretation.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
All right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Whatever we come up with, CMS will have to do independent of our recommendation anyway.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next one was drug/drug interactions. We had originally proposed that ….

Josh Seidman – ONC
Did you want to talk about evidenced-based order sets or go back to that? It's the next slide on the spreadsheet specifically about using order sets.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was from our original metric.

Josh Seidman – ONC
That's ours that ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That didn't … in the final rule. I think one of the reasons that it didn't appear in the final rule is what's … order set.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Exactly. What do they mean?

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
I was just about to ask that question.

Josh Seidman – ONC
Then I'll explicitly hold off on it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Drug/drug interaction and drug allergy alerts is part of the final rule, and what it says is enabled. We all know that there are issues with the current drug/drug interaction theme. For example, at Partners, something like 89%. Out of the box, 89% are ignored, and the reason for that is not because people don't want to watch out for drug/drug interactions, but the thresholds from the common drug database is out there is set so low that you get a lot of … not clinically meaningful alerts.

Deven McGraw – Center for Democracy & Technology – Director
We heard that too in the information exchange workgroup's hearing on e-prescribing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That could be one of the things we're … med errors is clearly one of the top priorities. That could be one of the things where we say, as our parking lot, one of the recommendations we give to ONC is that they sponsor in some way … more work on fixing this problem. It's a multifaceted problem, but we do need better drug/drug interaction functionality.

David Lansky – Pacific Business Group on Health – President & CEO
My impression from David Bates' work is that he had work with his leapfrog process, which is now quite established, both identified a small subset of, I think, 18 rules that he thought were really critical and should be universal and could argue for them at least whether right or wrong was the starting point. We could move towards saying there's a core subset that we would expect to be adopted and implemented. Then, secondly, the leapfrog approach was to actually have a reference test that you could run the system against an external validation set to show that it's doing what it's supposed to do against a dummy set of patient data. I think that would be a prudent task for us to explore for this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…and that study was whereas something like 89% were ignored out of the box, when they pruned it and just got the sort of important smaller subsets, two-thirds were accepted by the docs … so clearly that's where we want to go, and it's a question of how we write that. But I think what you propose is ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Is the question, would that be encompassed in terms of the measurement process, the quality process because people actually do look to those rules because those have been pretty well thought out in terms of clinical impact to patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene, are you asking if that belongs in the quality measures set rather than the functional set?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. Well, it seems like it should be part of that domain space in terms of looking at those types of interactions and what harm they prevent.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The way I introduced that in this little draft on that last column is I said percent serious drug interactions detected.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was a way of squeezing in some outcomes into a structural measure, what was initially a structural measure.

David Lansky – Pacific Business Group on Health – President & CEO
I have two comments on that one. I agree with the direction. One is that there is an issue, I guess, about e-prescribing users not downloading medication history in order to examine current meds, dispensed

meds that the patient may be on, which may trigger a drug interaction without it being … current prescriber, unless they do the download. So I think it's an opportunity here to expect that prescribers do access medication history before running this set of drug interaction checks. And, secondly, we create some kind of metrics around that. There's another one, but I'll come back to the second point. We really just asked about the medication history.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's the structural measure.

David Lansky – Pacific Business Group on Health – President & CEO
It says it pertains to the data sharing, the information exchange test, as well as a clinical quality test.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We'd want to write it so that they're not doing the process. They're achieving the outcome. One of the issues right now is not all, and I know … when I hit the button, the majority of the time nothing comes back. So that becomes a fruitless exercise. So it's the same thing we had with exchange. We want to wait for the infrastructure to catch up, and them measure them on the total, the drug/drug interaction of all the meds taken by the patient, but I don't know that we want to insist on a process like do we want to monitor the times the button is pushed?

David Lansky – Pacific Business Group on Health – President & CEO
I think it's a good challenge for us. We've got a four- or five-year window here to think about how do we incent both through the IE track and the data acquisition track, like we did with lab results reporting capturing if we do create this flow of information.

The second point I was going to make around it, which is germane, is whether—the PBMs run a lot of standard drug alert checks, whether the alert is fired, whether it's resolved, and in terms of a change made to the prescription and so on. So there may be some stop measures from the e-prescribing industry, if you like, the PBM industry, to capture in here that would speak to the issue of whether the alerts are being issued, and whether there are corrections being made to overt errors and to overt adverse drug events, as well as the possibility of measuring adverse drug events.

Christine Bechtel – National Partnership for Women & Families – VP
I have a question—and it may be because I'm not a doctor—and that is, if you implement the 18 rules that we talked about from David Bates' work and you're downloading med history, or even if you're not, then if you look at the outcome of percent of drug events detected, shouldn't that be closer to nothing anyway? How does that help us?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There are categories of drug events, adverse drug effects. Some of them you can almost classify as side effects. In other words, these are things that are certainly not life threatening and are just part of the mechanism of the drug, but they're producing a net effect of good. A GI upset for example could be one. You don't want to deny someone the benefit of that, and you make an informed decision, both you're advising the patient on what kinds of side effects. It could be a GI upset. It could be constipation, things that the patient would decide, no, I'd rather have the pain medicine and deal with that side effect.

The word that I use with serious and there's some degrees of serious too, how much of a clinical complication is there. Is it potentially life threatening? What percent of the time? Does it happen one in a million or one in 1,000 or one in 100? And those all should go into the decision-making process of the provider in conjunction with the patient. It is hard.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, from a patient safety point of view, so it's hard to measure this thing because, first of all, people with an EHR have zero serious drug interactions because they're not recording anything. It's not that they don't have any. They're not being recorded.

Deven McGraw – Center for Democracy & Technology – Director
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
When we build the system, we want them to increase their serious drug interactions detected. We want that number to be high because that means they're using the system. Then we want it to drop because they're succeeding.

Deven McGraw – Center for Democracy & Technology – Director
That's my problem.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Then the question is, do you create a … incentive for them not to report the interactions because they don't want it to go … and how do you work on this? The goal is to reduce drug interactions.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's the goal, and so sometimes we go for process measures because we want to force them to use it rather than be able to—and give up a little bit on the outcome side because we're afraid, if we create a perverse incentive on safety, from a safety research point of view, you don't want to punish people for reporting their mistakes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, the way it was written was, if you had a gold standard of serious drug interactions, then how many of those did you detect? How many did you prescribe? It's a little different. Your reporting problem is one the aviation industry had as well. When they required it, all of a sudden the … and the incentives … the incidents of reported near misses went way up, but just because they weren't reported before.

Deven McGraw – Center for Democracy & Technology – Director
But I guess I don't see how we could, backing into stage two and coming back to what David said, if stage two is about information exchange, I think it's important to make sure that providers are downloading med history, tracking refills, all of that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In response to what David said, I was thinking that could be something we build into the exchange, which is the care coordination because, in a sense, it's a different kind of med reconciliation.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You reconcile with everything that the patient is known to have. And one way to detect that is through the exchange on PBMs.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That might be a place we can build that in.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Paul, I'm trying to understand a little bit about this. Shouldn't the drug/drug and the drug allergy be detected at the time of CPOE?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So why is this really a separate item, and if we could get the CPOE to report the percent of serious drug events or drug allergy events that were overted rather than—because I don't know how we're going to get to a point of reporting serious things detected. The whole intent is not to even let them happen.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. I would agree. I think that what we really should be doing, the requirement should be the reporting of adverse drug events because you also have drug age interactions. We had talked about the … criteria for drugs that are contraindicated based on age. The med reconciliation piece has to fit into this because even after you download all this information about what pharmacies have given to people, you have no idea whether they're actually still taking those or whether those are old orders that are just still in the system. So I think, for me, the key is the med reconciliation. That's what says what people are really on, and then the endpoint is all drug adverse reactions because that's what you want people to examine at the end of the day in order to create some mechanism to prevent that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. That is clearly what we're trying to measure and prevent. It's just hard to get as coded information. A way you could do the percent serious drug interactions detected, so let's say there are 20 rules that somehow the community decides that these are important drug interactions. Then you would detect how many in your patient database are on that combination of drugs that are listed as high priority, for example. And then you would also know how many times this fired, this drug interaction detector fired, and that's the percent there.

Of the serious, the high priority serious, let's say it's Coumadin interactions with other drugs, Coumadin and Amiodarone. How many patients do you have in your patient database that are on those two drugs? Of those, that's the denominator, how many had an alert fire? That's basically expressing did we appropriate detect these serious incidents. Now you also want to know how many … alerts and how many low priority alerts did we … the physicians with, that kind of thing, but first, let's figure out whether we're catching the serious stuff. That's the draft on the table.

Neil Calman – Institute for Family Health – President & Cofounder
Right, but you're also missing a huge category of events, which are those, for example, where drugs are contraindicated because of liver failure, because of elevated liver enzymes, or another drug that's contraindicated in renal failure. I think that you're dealing with the process upfront, but we're not really dealing with the real issue. What you really want everybody to do is to have a universal reporting system, and maybe we need to think about how we're going to signal this to be put in place, some sort of universal reporting system of adverse drug events, and then track that backwards. Otherwise we're only dealing with a small portion of what really creates bad outcomes for people.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The other part of the challenge, I think, and it's to echo that, to get to where we need to be, the specificity has to be there because you just can't say what you said and understand people and have customers or providers understand what you really want them to do. So that specificity, whether it's 18. There's a glide path to get them, or whatever it is, but it ties into what Neil said. Ultimately, there's some end thing you're reporting to, and then there's a glide path for them to get there.

Deven McGraw – Center for Democracy & Technology – Director
I think the only thing I was going to add was that if we're heading towards something that is going to require institutions to publicly report on an adverse event, I think we might want to consider whether there's an option for them to not have to report that to CMS, but to report it to a patient safety organization, which is the only thing that we have in existence that is at all mirror to the aviation system. So it's not necessarily on a national level, but at least you're examining that as part of a process when you're not putting something out there that could be used to harm the institution. But even that is not a

terribly great solution because there isn't sort of a requirement, as part of the PSO process, that that get wrapped up into some sort of national system where we can all learn from it versus just single institution learning.

David Lansky – Pacific Business Group on Health – President & CEO
One thing we might ….

Neil Calman – Institute for Family Health – President & Cofounder
Isn't that what we're really— I mean, if you get to the sort of population part of this stuff, I think we're finding out, as you sort of morph towards stage three, all of these concepts are starting to merge: the exchange, the patient involvement, whatever. But ultimately what we're really trying to achieve is the improved outcome, and so to get a reporting system in place, just what you were saying is really what the nation … help us … all kinds of ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just for your information, Neil, you're breaking up every other word, so you must be on a cell phone.

Neil Calman – Institute for Family Health – President & Cofounder
(Inaudible.)

David Lansky – Pacific Business Group on Health – President & CEO
…comment about it. It may be worth separating the two components of this issue and handing off the hard part to the quality measures workgroup.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
…that's what I was doing.

David Lansky – Pacific Business Group on Health – President & CEO
And so ….

Deven McGraw – Center for Democracy & Technology – Director
You're co-chairing that ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right.

David Lansky – Pacific Business Group on Health – President & CEO
…I know, this is suicide …. We have a track within the quality measures workgroup on safety and medication safety lives there.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
The challenge that we're identifying now of saying what is the outcome measure for adverse event reporting could be handed off to that discussion. One of the things that group is likely to do is say are there measure gaps, and do we need to identify people in the field, researchers, whatever, who can help us answer the question we're posing right now? What is the best way to measure adverse event rates, and as well as Deven's point of to whom should they be reported and how? That would sit, I think, Josh, within our purview in that other group. Then this group could stay focused more on sort of the process measures, if you like, the instrumental measures, whether it's which alerts are built in or how are they tracked or how are they fired or what do we think is worth counting to show that the user is making meaningful use of the technology, not necessarily that they're achieving the impact on the outcome.

Josh Seidman – ONC
Right ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So one of our goals … but from the process point of view is we have a particular problem, which is, we have products. Those products are attached to interaction databases and they don't work. One of our motivations was to find a way to create incentive to get those things to work finally because right now it's just something that you have it. You can check it off as a feature, and then everyone has to turn it off and redo it themselves. How can we force the nation to create something that works? I think that's what we would use this row for is to fix that. I understand there's also med reconciliation, HIE, but this row, I think, is to fix that problem. I agree with separating the reporting. The hard part for you guys will be I don't want to create an economic disincentive for reporting. You've got to work that out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then to Deven's point about the process and reporting and the protection, as you recall when we had our EHR safety panel and recommendations, we recommended that an independent organization go study that further. So I think that is underway too. So we actually are covering through the various activities sponsored by HIT policy. There's quite a lot going on.

David Lansky – Pacific Business Group on Health – President & CEO
Then back to George's comment, if it's about process here, then should it be some sort of measure of potential serious drug interactions that were identified. And if we say it's among this 18, this list of 18 or something like that where you have to at least put it in place and say how many you found, and whatever subset we decide should be a measurable item.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think, consistent with that, if we put in our comments, we'll work it out later the details, we need to make sure they catch this predefined and, as a footnote, we either need to identify what's accepted as predefined or ONC needs to cause to create this list of things that we need to watch out for. The other part of the footnote is we have to find a way to reduce the noise. This whole notion of substantially increasing the yield of these drug interaction alerts is our end goal. We have to write it in a way that's specific enough that vendors can interpret it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But if you're specific in the harm you're trying to prevent, right, and you focus on those, then at least maybe we can get improvement in terms of the processes and the interactions around that space as a start. I think the more specific you could be, these are the types of harms … into the drug/drug interaction. Then at least you can get the drug manufacturers and the vendors starting to move down that path to improve at least those processes ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't think we can do that without talking about the noise because they'll say, we've got all the serious ones. The problem is, you've got all this other stuff that's not serious, so we have to speak on both sides if we're going to get the problem fixed. We'll come back to that part of it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The outcome will lead to the quality measure … in the sense of how are we going to measure that patients are better off. But right now we're talking a bit about the functionality and making sure that we can get useful clinical decision support surrounding med drug interactions. We have to find a way to say that explicitly.

Josh Seidman – ONC
I'm typing. So far I have employee drug interaction checking on a small number of important interactions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, be able to make sure that the function can alert people to some subset of important serious drug interactions, and the footnote is that we're going to have to figure out how to define that.

David Lansky – Pacific Business Group on Health – President & CEO
I understood that AHRQ actually has a project to do that. AHRQ took—I don't know if someone here knows—from the leapfrog work and the reported leapfrog released this year showing some patient safety issues that AHRQ had undertaken a study to refine the list of important testable interactions. We should find out about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. The footnote says it either exists, it's going to exist, whatever, or we need to cause it to exist. And the flipside is we've got to reduce the false positives … point of view.

Christine Bechtel – National Partnership for Women & Families – VP
How does this relate to the discussion we had about downloading med history?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're going to cover that in the care coordination, in the med reconciliation.

Christine Bechtel – National Partnership for Women & Families – VP
Right. Okay. All right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What we haven't said is where is, and probably the endpoint is stage three, what we've just described because it'll take time to build that evidence base and have those tasks. In stage two, there's clearly a mid ground between turning ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Isn't there a glide path? I mean, you should have a glide path. If you defined 18 … I mean, it's much better if we put in place the technology and start to build a glide path there, I think.

Christine Bechtel – National Partnership for Women & Families – VP
A question, shouldn't the technology be in place based on the requirement already in stage one? We're just asking them to focus on the use of some subset of rules.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, the variation in that report from leapfrog is all over the map, so I can't answer that.

David Lansky – Pacific Business Group on Health – President & CEO
The certification requirements now strengthen or offer more specificity around this CPOE decision support?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's not, I mean, there's the capability, but I don't think ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For drug interaction, at least, the only test is enabled.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, but all this variation, I'm sure there's going to be a lot of variation around what each vendor can do to meet whatever subset you come to in the very near term just because there are not standards, and it hasn't been a focus.

Christine Bechtel – National Partnership for Women & Families – VP
I guess I thought that the 18 was the starting place because they're common and recommended and should be universal.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
There's a lot of variability around that space.

Christine Bechtel – National Partnership for Women & Families – VP
I know there is. I think what I'm looking at is what should be the case in stage two.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If we name ten, you'll write ten alerts, and you won't build a medication interaction system. If we say do them all, then you do 1,000, and the doctors have to ignore it. We have to be careful not to err on either side, but I'm not naming 100 because I can't name 100. So what I want them to do is use a drug interaction system that can grow over time and not something that's not manageable like we name ten. They do ten alerts. They're done.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. That's what the glide path is going to be.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, I think what you type for stage two, that was our goal for stage three, and we're trying to come up with a stage two kind of a thing on the glide path.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It may not be an appropriate number of small, of important ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. I think George wrote it correctly based on this last comment.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
If it's two out of 18, it's just a small number at this point, right?

Christine Bechtel – National Partnership for Women & Families – VP
If our goal for stage three is only a small number, I think I would take issue with that because I don't see how you get to, Paul, your idea of serious drug interactions detected. It should be a fairly high percent in stage three without doing, at minimum, a small number in stage two. I think what George has is right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it's just an interpretation of small. Small is 100 out of 1,000 is pretty small, but it's very important.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But even if, I mean, realistically, even by stage five, if there were those 18, which are proven to not … and again, we've got children's hospitals. We've got a lot of variations still out there. But I think that would be good enough, and then that's like stage three. This is the start. It's not the end.

Christine Bechtel – National Partnership for Women & Families – VP
So why don't we have … action item for ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Getting consistency and reducing the variation would be amazing.

Neil Calman – Institute for Family Health – President & Cofounder

…I mean, you could do 18 measures and have two that are relevant … care. That wouldn't be really helpful stuff to reducing med errors in an outpatient setting. You could have none that refer to the medication errors that are in ICUs. I don't know what these 18 are or whether they spread across the whole spectrum, but if they do, they're unlikely to be significant enough. I think we need to call this out. This is an incredibly important area, and one that we need to be more strict about and having higher goals.

I also just want to say another thing, which I was sort of jumbled up about before. But there are a lot of other interactions we're not really even focused on, and I want to make sure that at least it gets to David's, to our other workgroup, which is the drug pregnancy interactions. There's just been recent stuff published on that and the extent to which people are being prescribed drugs that are contraindicated in pregnancy and lactation, and the drug disease interaction. So we've got to be able to look at this broadly, otherwise I think we're just playing around the edges of a very serious problem.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're putting that in the notes, Neil, in terms of right now we want to certain get drug/drug interactions going because we don't have it, and it's so important, and the work needs to be done. But one of the ways we can expand it perhaps in 2015 is to include the other drug interactions with other things like disease, lab tests, etc. I think, at this point, we've sort of gotten the concepts down, and George and I can wordsmith it and try to get our intent captured better in what's listed, and then we'll have that as a discussion in our followup call.

The next one is e-prescribing, and the current notion is that it be used for 40% of the permissible drugs. Right now, still controlled substances are not permissible, but they could become, so that's the current final rule …. The question is, how far up do we want to go?

Art Davidson – Public Health Informatics at Denver Public Health – Director
The other point was that in August of last year, the policy committee recommended for stage two to include discharge in the hospital setting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so the thought was that currently inpatient systems do not have the capability of prescribing for homes, for basically to pharmacy versus the in-house pharmacy, and we wanted to make sure that was possible in stage two. Does that seem reasonable, Charlene? It's certainly something we want to do, so that's ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I thought Josh was going to speak to the question about e-prescribing with controlled substances. I'll have to admit that I haven't read that rule, but I thought it was interim final and allows it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Really?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But with …?

Christine Bechtel – National Partnership for Women & Families – VP
What is this?

Deven McGraw – Center for Democracy & Technology – Director
We should check on it. Let's just make an asterisk and figure out what's going on there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Christine Bechtel – National Partnership for Women & Families – VP

It would still be the same because it would still be permissible prescriptions.

Deven McGraw – Center for Democracy & Technology – Director
Right, but we don't need the word permissible ….

Christine Bechtel – National Partnership for Women & Families – VP
However, there's probably … universe. Right.

Deven McGraw – Center for Democracy & Technology – Director
I'm not sure there'd be a universe ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the goal then is the final goal is that all information is transmitted electronically for a number of reasons. Clearly it's efficient. It's more accurate, and it has the potential for more checking. The only pull back from 100% is some of the consideration that CMS wrote in the final rule, which is some patients don't know what pharmacy they're going to, so they want a paper prescription, and that's always going to be the case. That's why what I wrote there was not 100% and not even 90%.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Does this one belong under? I know we've got the connectivity piece. It feels like we want them to write the prescription in the system, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's true.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Whether they transmit it or not is a separate process, so I don't know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But I guess it got put here because of quality, safety, and efficiency.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right. I think you need it here, but it overlaps the issues that we have in the other area is all.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So far, we are, and actually, here's another way to write it. Instead of 80%, it's really 100% where the, well, 90% according to patient preference.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I agree with what.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And then the midpoint is some other number plus adding hospitals into the mix.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The indication was 60%, right, CMS is 60%?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point. Go ahead and capture, well, it didn't say 60%. Sixty is CPOE, not the transmission.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. All right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we could split the difference … turns out to be about 60%. So it's 90% transmitted … 90% of the patient preference is sort of the qualifier there.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. I think that's a better way to go, then it'll be transmitted or not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And it seems like that should be the 60%.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are you suggesting that … 60% plus hospitals as well? We can do that as a placeholder anyway.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't know if you want to put 60% in terms of hospital prescribing. Maybe we could think about that measure, but at least get it going in stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, there are patients that aren't prescribed. There's a whole bunch that are out of the denominator.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great.

Josh Seidman – ONC
I'll have to fix that later. What did we do, 60%?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the stage two was 60%, including hospital discharge. Tony, we're working through the template you may have seen in the other spreadsheet ….

Tony Trenkle – CMS – Director of OESS
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next item is demographics, and a big part of the reason why we had this is because we want to be able to, in other categories, report on your quality measures stratified by disparity variables. The notion right now is that for half of your patients, you have this information and a proposal is to go to 90% by stage three.

Christine Bechtel – National Partnership for Women & Families – VP
So, that makes sense to me, but on the other hand, if you have to use demographic data to stratify quality measures, do you need the reporting requirement for the collection of the demographic data in the first place? One topic that occurs to me is, in the unintended consequences area, is it possible that we would select quality measures that capture a narrow subset. So somehow if we don't have the data collection requirement, it means that in effect they're really not collecting demographic data across the patient panel. I don't know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This maybe goes back to the value of having the information in the first place. We wanted to drive, even drive decision support based on some of these variables. If you don't have it on everybody, it's the same thing. Then it's just not useful. There are times when we're trying to exercise the whole thing, and there's times when we really do want to have that horizontal of just all patients.

Christine Bechtel – National Partnership for Women & Families – VP
So we would leave this in here, which ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It seems to me, if other people agree.

Tony Trenkle – CMS – Director of OESS
Can I ask a medical legal question maybe of our …?

Deven McGraw – Center for Democracy & Technology – Director
Sure.

Tony Trenkle – CMS – Director of OESS
As the EHR becomes the medical record for medical legal purposes, doesn't it have to capture certain relevant demographic and other items? It may be an incomplete set for our purposes, but at what point does this stop being a supplement to the paper record and it becomes a legal document and, therefore, some of these things are expected?

Deven McGraw – Center for Democracy & Technology – Director
It stops becoming a supplement when the office transitions over, so record keeping requirements are largely in state law, and so you can keep it in paper. You can keep it electronically. The test is not the medium in which you keep the data, but do you have a system for keeping the data? I actually don't know if the state laws are terribly specific about the type of demographic data that you have to collect, including race and ethnicity. It's a good question, and I don't know the answer, but my sense is that it's quite possible that if there are state laws that do it, it's not universal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For example, California does require it, but they're not specific. So, in some sense, this would, for the folks that qualify under this program, end up being more specific than our state law. But I think it's in a direction that the science is going in terms of what information did you need to have in order to make relevant decisions on those patients.

Christine Bechtel – National Partnership for Women & Families – VP
I guess I would almost say that in terms of stage two, if we're at 50% now, it probably should go to 80% or 90% in stage two because of the need that we have, the recommendation that we have to stratify in that also what we should recommend is from our public hearings this summer using the ILM categories.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's going to be really, in the timeframe, challenging for stage two to get that in because it is pretty complex, let alone implemented. You might want to put that out there as stage three as a glide path.

Christine Bechtel – National Partnership for Women & Families – VP
But, Charlene, they already have to do it for half of their patients in stage one.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
No, I'm not saying that they shouldn't capture the data. I think the software is in place. They can move up the glide path. But adding those new code sets in and implementing that to the level to catch that level of granularity is a pretty significant ….

Christine Bechtel – National Partnership for Women & Families – VP
You mean the NLM ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, the IOM piece.

Christine Bechtel – National Partnership for Women & Families – VP
Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Is the granular code in stage one? I don't know.

Christine Bechtel – National Partnership for Women & Families – VP
No, it's the ONC standard in stage one.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But I think you can raise the bar because the software is there, but to add that level of stratification in.

Christine Bechtel – National Partnership for Women & Families – VP
Right. Charlene is saying you could do 90% based on the current data collection, but if you add in the IOM variables, it might be more difficult.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. The rules … we're using for stage one was 80%, so maybe we could go to 80%, from 50% to 80% in stage two, and then go to 90%, including the IOM granular.

Christine Bechtel – National Partnership for Women & Families – VP
For stage three. I think that makes sense.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And then we've got a glide path, and we can get that feedback.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So only in stage three including ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, 90% including the IOM categories. And for stage two, it was 80%. That's correct. Making progress. The CQM is covered in a separate workgroup. The problem list, the problems, meds ….

Christine Bechtel – National Partnership for Women & Families – VP
So are we taking it off the table?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's being handled. It's off our table.

Christine Bechtel – National Partnership for Women & Families – VP
Which is?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The CQM.

Christine Bechtel – National Partnership for Women & Families – VP
Well, what you have here reads like a function as opposed to what I think the quality measures workgroup, David, is going to do is say … percent of patients with diabetes have lipid levels ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me clarify the certification for stage one. I thought they actually, as part of certification for stage one, these quality reports have to come on the EHR already.

Christine Bechtel – National Partnership for Women & Families – VP
They do. You have to demonstrate this ….

Tony Trenkle – CMS – Director of OESS
Right. Yes, for the certification functionality.

David Lansky – Pacific Business Group on Health – President & CEO
And that they can be stratified by other variables, say ethnicity or language or not?

Tony Trenkle – CMS – Director of OESS
Not for stage one.

David Lansky – Pacific Business Group on Health – President & CEO
That's, I think, the test.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

David Lansky – Pacific Business Group on Health – President & CEO
For the quality measures workgroup, I think where we'll start talking is that you can show your ability to stratify critical indicators of disparities by these variables and probably define a small subset of ones that are to be reported.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
My challenge, just for why I raise it, is that I have an issue with the end goal, the 90% reported directly from EHRs. If we're not considering this, then it probably should just come off the table, and the quality measures workgroup will … quality measures.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What's your challenge though? Let's see if we can handle it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You're not going to like it. No, the issue that I have with it is I think it's no the meaningful use of quality measurement isn't that you get almost all of your measures out of the EHR, for example, as much as it is the outcome goals that you are achieving, and they should also come out of it, but as an end goal for stage three. I don't think so because I think there are some areas where we're going to want, particularly by 2015, where we need to drive to a place that leverages EHR data, but isn't limited to it. Patient experience is one of them. So I think that's the issue that I have there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This may be a good time to ask you about certification. The rules, as I read it, is that the quality measures have to be certified. The EHR vendor has to be certified so that it can produce these quality measures. Clearly there's been a lot of comment, and that includes what Christine just mentioned that a lot of people extract data from the EHR and other places and then use that system to produce the quality reports to whomever. Yet that seems like, in a literal translation, to be actually not certified, and that organization would have to certify whatever systems they used. Is that an accurate interpretation of the rule? Is there any flexibility, or how could we help?

Tony Trenkle – CMS – Director of OESS
That's exactly right. The functionality to meet meaningful use has to be certified, so whether it's one module or several modules. If you can't meet that without making changes to the module that you're using or whatever other systems you bring together, that all has to be certified as a unit because, under the law, we're required to accept certified EHR technology criteria. So we've been told by our OGC that

any meaningful use criteria that's not met through using certified EHR would not be considered part of the criteria to meet it. So if you have to modify your system or systems in any way, you would have to get that part certified. So it should be a one-to-one functionality and criteria.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It could mean the majority of healthcare organizations would have to go to all of these accredited, certified bodies for this piece to get certified.

Tony Trenkle – CMS – Director of OESS
Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…handle ….

David Lansky – Pacific Business Group on Health – President & CEO
…Tony, we were going to have in the quality measures workgroup a subgroup working on delta measures, measures that are longitudinal over time.

Tony Trenkle – CMS – Director of OESS
Right.

David Lansky – Pacific Business Group on Health – President & CEO
Which implies some ability to capture data over time and then do a computation for it.

Tony Trenkle – CMS – Director of OESS
Right.

David Lansky – Pacific Business Group on Health – President & CEO
Each time we explore a functionality that pertains to quality reporting, there isn't in the current certification program as intrinsic to the product, to the certified EHR technology. I'm trying to imagine. Can we imagine a module, which is external to the user, so the HIE, let's say, in Nebraska provides a quality reporting function and captures data from several sources, computes the quality measure, and reports it to ….

Tony Trenkle – CMS – Director of OESS
Right, and that's actually one of the things we'll have to get some legal feedback on is how far that definition goes. But the understanding that we got from them was that it had to be certified as EHR technology, and that's how ONC actually wrote the certification and standards regulation as well.

Christine Bechtel – National Partnership for Women & Families – VP
But I think what David is saying is couldn't you have an EHR that is certified to be able to report quality measures, but they report it to an HIE. Then, for the purpose of CMS and payment, it may be that the HIE provides CMS with summary data.

Tony Trenkle – CMS – Director of OESS
Yes. That's fine. Yes, that's right. Yes, or registry or whatever. Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me go to Christine's addition, which is, let's say some of the new quality measures will include input from patients.

Tony Trenkle – CMS – Director of OESS
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's obtained through an EHR, and the way you obtain that is probably out of scope for the EHR certification, so how could we end up …?

Tony Trenkle – CMS – Director of OESS
I think what we need to do is kind of look at some of these potential issues and then kind of do some research and talk to our legal folks and see where they stand, but you raise some good points. As we proliferate the enterprise, it'll bring up a bunch of these types of issues.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So a note to ourselves then is when, in the blue, 90% report directly from an EHR.

Neil Calman – Institute for Family Health – President & Cofounder
Let's take out the word directly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I'm sorry. What did he …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I'm not even sure that we want to necessarily say that our goal is that it all has to come out of something labeled as an EHR.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We need to use HIT technology to be efficient and to get data from wherever it originates, and sometimes it originates from the patient. And get standardized quality reports to the recipients, whether that's the public, CMS, or states.

Christine Bechtel – National Partnership for Women & Families – VP
This is where I guess what I'm thinking is this is a functionality. It's the ability to report.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Christine Bechtel – National Partnership for Women & Families – VP
It's almost like drug allergy checking enabled. So if we have quality measures from the quality measures workgroup that are HIT enabled, the system is going to have to be able to produce those measures, so do we need this line?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The line says CQM report electronically. That's useful.

Christine Bechtel – National Partnership for Women & Families – VP
Right, but they're going to have to report electronically if the next column, which we don't have because this is all functional stuff, so if the next column over on measures includes percent of patients given aspirin at admission for heart attack, their system is going to have to be able to report CQM electronically. Do you need the functionality line when it is de facto implicit in the measure that they're going to have to do?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The functionality just because it's part of meaningful use qualification?

Christine Bechtel – National Partnership for Women & Families – VP
Right, but as part of the measure that's going to be in the column that we don't have here.

David Lansky – Pacific Business Group on Health – President & CEO
So it's the tree pruning, right, that I said earlier.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
Maybe this is one that could end up deleting the office measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Because it's going to exist …. Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think the discussion around what's a certified EHR in this space is really important because, am I just going to feed the content of the measure to somebody? Then what do I get certified on? If I have a data warehouse, I have to certify that. So this is a very complicated space.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is this already being handled by … by the HIT Standards Committee? Are they discussing this issue?

David Lansky – Pacific Business Group on Health – President & CEO
Not that I'm aware of.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Typically you feed it into a data warehouse, and that has to be certified, and that collects data, but then as you start to transcend it further, do I just want to feed it? Is that what you're measuring me on, what do I feed?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This maybe we come back to as a policy issue because it is a policy. You can understand that the spirit of both the law and what we intended is that you capture data from authoritative source, store it in a standardized format, and apply it in standardized, quality measures, so that it's comparable. I don't think we intended that only one way be certified or one system. I think we need to probably both seek OGC council on what the law requires, as well as perhaps give input to the standards committees, as they write the certification recommendations.

Tony Trenkle – CMS – Director of OESS
Right, I think that's ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we got a little bit out of … so one of the things that you do want to make sure happens is that these data are captured in the work flow in meeting standard definitions because otherwise we can't compare. That has to be, in a sense, certified. But how it gets to the recipient of the reports seems a little bit extraneous to the ….

Tony Trenkle – CMS – Director of OESS
As we said in the reg, I would just move onto the reg, beginning in 2012 with Medicare, we would provide one or more alternative options for electronic submissions, which may include intermediaries. It kind of laid out the glide path that you ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's one point. It takes care of the HIE.

Tony Trenkle – CMS – Director of OESS
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But the whole notion of whether we combine ….

Tony Trenkle – CMS – Director of OESS
No. I understand your second point.

David Lansky – Pacific Business Group on Health – President & CEO
it may be worthwhile somewhere in our process to speak to the question or architecture, for lack of a better word, and what this idea of intermediaries that the rule describes, how we think that, what that requires of the EHR user because whether the EHR users have common, universal requirements that end up being certified by the standards committee language where all the are is an export, a data export function to the intermediary is a pretty big issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
it would be a certified EHR, a certified intermediary, or a certified module that sits on top of the EHR, right? I mean, any of those three, but they'd all be certified.

Deven McGraw – Center for Democracy & Technology – Director
No, we don't have certification of intermediaries required.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But they'd have to go to prove what they have does the task. If they're saying that they can provide a CQM, they have to go and show that to someone to say ….

Deven McGraw – Center for Democracy & Technology – Director
Yes … if a provider is going go to rely on them, they have to be able to demonstrate to the provider that the can do what they say they do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. I don't mean that we have a certification, but they have to prove that they can do it.

Deven McGraw – Center for Democracy & Technology – Director
They have to show their stuff.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
I think, particularly for the HIE world, which is also very dynamic right now, this is an important signal. If they're going to be certifying quotes to satisfy CMS or other reporting requirements on behalf of the users and their community … what we should send soon.

Tony Trenkle – CMS – Director of OESS
Yes. I think we've got it covered in our reg, but I didn't bring the certification reg. Actually, I left it at the Humphrey Building, but … covered under that. I mean, it would seem to be a one-to-one would be needed there. So if there's a gap, we need to take a look at it and make sure that's been clarified. If not, it would be a good effort for the standards committee to look at that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now to try to manage our time, I'm going to try to take the next few as a clump, and that is the problems, the meds, and the med allergies. They are thought to be something we should all be doing currently, which is how they got assigned an 80% threshold. The notion, the definition of having this is having one or more or the notion of designation of none. Our original thought was that the value proposition for all of the users of the EHR is that they'd be accurate and up-to-date. In my proposed draft is that we go back to the concept of up-to-date, and I realize that that's hard, but both to measure and to make sure it happens, but that's really where the value is.

Christine Bechtel – National Partnership for Women & Families – VP
I thought that was already part of, I thought it was up-to-date problem lists and active meds and active allergies … active means.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the way it's written is that it is essentially … and populated, but it's not necessarily populated with up-to-date information.

Christine Bechtel – National Partnership for Women & Families – VP
What does active mean?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Active is a contrast with past medications, which we also store and are useful to us. But right now we're trying to say if I have a patient in front of me, what are the active problems, meds, and allergies.

Christine Bechtel – National Partnership for Women & Families – VP
So current, different, up-to-date meaning including historic.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. Up-to-date meant today, do I have a complete list of their problems, a complete list of the meds, etc. There's sort of a distinction, and you're asking for a definition of active or current. There's sort of a distinction in terms of how the professionals use it.

Christine Bechtel – National Partnership for Women & Families – VP
We should be clear about it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're right.

Tony Trenkle – CMS – Director of OESS
Paul, one thing …. I'm sorry. Go ahead, David.

David Lansky – Pacific Business Group on Health – President & CEO
I just wanted to clarify just your qualitative feeling of what does up-to-date mean. How would you operationalize that as a standard?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I acknowledge that that was hard. One of the ways that we did it was you'd have peers review yours, so you'd look at the list, and you look at the progress notes. Does the list capture everything? I think that's admittedly hard to do in an automated fashion, but it's the important end game in a sense because it's very high leveraged information.

Tony Trenkle – CMS – Director of OESS
I just wanted to mention just a couple of things. Sorry I came late, but three things we're doing at CMS, working closely with our colleagues at ONC is, one, we've vastly expanded our frequently asked

questions list, which hopefully can deal with some of the issues that both you gave to me, and it may help you in terms of your planning for the future stages.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What's that now?

Tony Trenkle – CMS – Director of OESS
We're up to like 80-some FAQs, and we've got more in the pipeline. Secondly, we will be issuing a corrections notice to deal with some of the inconsistencies that people have seen in the regulation. That should be going to clearance shortly. Then, third, we've developed detailed specifications of each of the objectives and measures, the structural objectives and measures under that. I guess, lastly, our quality folks are issuing more detailed quality guidance that they're going to be putting up on the Web site as well. So hopefully by those that should not only help clarify issues people have raised, but also help you all, as you plan for the recommendations on future stages.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In addition to FAQs, do you anticipate any kind of guidance document that are a little bit more directive?

Tony Trenkle – CMS – Director of OESS
That's something we'll have to take a look at. At this point, what we're trying to do is we've gotten a deluge of questions, and we've noticed that there are some inconsistencies that we need to correct. Once we get the total suite of FAQs out, specs, and the other information, then we'll decide. But I know for the quality area, they are issuing a more detailed guidance document.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That'll be very helpful. Thank you. We need to define current versus past, and what we mean by up-to-date.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The metric now is at least one entry.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The metric now is at least one entry or an indication that there is none.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That there is none, right.

David Lansky – Pacific Business Group on Health – President & CEO
Is there a way to validate against a most recent visit? What I'm trying to get at is avoiding any unnecessary use or overuse of visits, for example in order to be up-to-date. If up-to-date is the last 11 months or something, then we'd be forcing a process that may not be necessary if we said that these three lists—problem, medication, allergy—have been indicated to have been validated or are current as of the most recent visit, whatever that means, which is itself a problem as we move towards e-visits and so on, but nonetheless, is there some way to validate it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just trying to answer your question about what do we mean by up-to-date sort of professionally it's what's the information at hand. So it does not force new visits over a certain period of time. It certainly would include the thing that you just mentioned, e-visits. So when you contact folks, you always want to make sure there's no new information that could be important to their care, so those three things—the problems, meds, allergies—are something we sort of routinely ask about. Do we always document it in this section of the EHR? No. That's a defect, a deficit that we want to correct over time because ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. One consequence of going to real time data exchange is you have to have that data you just talked about up-to-date. So from the practice, for me to send out an automated discharge or an automated continuity of care document or whatever, I have to have an up-to-date problem list and allergy list. The same thing in the hospital, I can't wait now until after discharge. I have to make sure. I mean, it may not be as current in the hospital as you might want it, but that outcome is already happening because we have to exchange data, so I don't know if we can use that at all because, especially in the practice, that goes out. You give the patient that record when they leave. I mean, the same thing in the hospital; you're going give the patient that discharge instruction. It's going to have that information on it. Some of that is already happening because of the need to be able to exchange data.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
One thing we see go wrong with med reconciliation is that the doctors will put in meds. If there's no list, they'll put in … try to put in the right one. If there's already a list, they ignore it. The feature we could be forcing in a positive way to have some way to confirm that you've checked the list. On the next visit, there's some button you have to push that says okay. If we … force it into the workflow or not, that's a decision, but that would be the closest thing I can think of is a process variable to insure that it's up to date. If … then I'm not going to be comparing it to anything. I just want to know that they confirmed it. But if you have a lot of things you have to say yes … then it becomes useless, so that becomes the tradeoff.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The other thing, to do drug/drug interactions, you have to have update problem list, allergies. I mean, these lists have to be up-to-date. It's a byproduct of implementing the system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what I was saying. This is an outcome almost.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. That's why this structural measure, we're really saying it's the end goal. It's a huge end goal.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So are we saying …?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's a byproduct. We have to do it, right?

Christine Bechtel – National Partnership for Women & Families – VP
You have to keep your problem lists up-to-date ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
So are we saying that a problem list that comes from a hospital discharge needs to be integrated into the EHR, the ambulatory EHR, right? Isn't that what you're saying?

Neil Calman – Institute for Family Health – President & Cofounder
Not really.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't think we went that far yet in the discussion because I think we were just … at least in the near term, but it doesn't preclude that in the long term, but at least at a minimum now because the way we're rolling this stuff out is you have to have current for some percentage problem lists, med lists, and allergy lists to be able to create the document at discharge. So it's forcing currency there that wasn't there just because of the exchange requirements.

Art Davidson – Public Health Informatics at Denver Public Health – Director
But that's for the hospitals. What about for the ambulatory practices as well? How do you incorporate the data that has been established elsewhere? Isn't that part of the process of stating what an up-to-date list is?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And I think that ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
That are deactivating problems?

Neil Calman – Institute for Family Health – President & Cofounder
There are lists. There are problems from the hospital that are not relevant necessarily in the outpatient setting, so there's some process by which it's a reconciliation process, just like the med reconciliation.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Actually, you're exactly right. We don't even want to go there with problem lists. We actually talked about this problem list reconciliation process. I don't know want to put a new one on the list, but I think you're right.

Neil Calman – Institute for Family Health – President & Cofounder
No, but that's exactly what goes on.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Am I hearing any disagreement with, one, the concept of up-to-date. We'll have to wordsmith being the precise definition, but having that be true for virtually all, and I don't know whether it's 80% or 90% at stage three. The concept is okay. What do we think about the threshold? Part of the not 90% is somebody may not have even come in, so are you completely up to date?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But aren't you getting it? How many ways do you have to go after it? To do your measures, do you have to get it? To do your drug/drug interactions, you have to get it. To do your exchange, you have to get it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's implicit, and I think some of the value of this is to be somewhat educational because I think people, for example, if you say, well, we already have a paper problem list and med list, don't recognize how important being up-to-date is when you start to exchange with everyone, and people start relying on what you say. That's a translation or transformation that I'm not sure making it just implicit is good enough. Is that making sense?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The provider community knows.

Neil Calman – Institute for Family Health – President & Cofounder
I don't think the percentage here is really going to be all that helpful because, as you said, Paul, how you go about deciding whether something up-to-date is like the most critical issue. I feel like we're trying to multiply something with six decimal places by something that's like estimated.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Neil Calman – Institute for Family Health – President & Cofounder

The process of deciding if something is up-to-date is so inexact that putting a percentage on it almost loses its meaning.

Christine Bechtel – National Partnership for Women & Families – VP
Do we need to parking lot the draft … for up-to-date.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Need to parking lot of our method. Right.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Okay. This may be an appropriate time for a break. What do you think about 15 minutes or 10 minutes? George is asking me ….

Deven McGraw – Center for Democracy & Technology – Director
That's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So 11:10, we'll resume. For coming back together, and where we left off, we had finished with the, well, actually, wait. Did we finish with the problem list and active meds? We talked about up-to-date. We talked about defining it and getting back to you with some better definitions.

Vital signs is a basically at the 50% mark and, as a proposal, thought we would raise it to 80%, and over 65%. Why did I do that? The way that CMS designed some of these measures is you wanted to be able to use the denominator, either all your patients, regardless of whether they're in the EHR, or things that are part of the activity. So they had spec'd 50% for all patients, if I'm remembering correctly. If we wanted to raise it, for example, do people get vital signs on every visit for kids like blood pressures on kids? And that's where the hedge was basically.

Deven McGraw – Center for Democracy & Technology – Director
Yes, but I think it's odd to draw a line at 65. I mean, we had this issue on another measure in stage one, and we ended up, I think, with respect to minors. We always have this problem with respect to specialists and pediatricians where the population needs are slightly different.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Deven McGraw – Center for Democracy & Technology – Director
I think we need to think about that, but I think the line at 65, I mean, I get my blood pressure taken when I go in, and I'm creeping close to 65, but I'm not there yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Totally open to whatever proposals people want to put on the table. Just to remind us, so the rule said record vital signs, which are height, weight, blood pressure, BMI, and growth charts for patients 2 to 20 years old. That the measure was over 50% of unique patients who have an EHR or whose data is in an EHR have height, weight, blood pressure recorded as structured data. So it's a little complicated, which is ….

Neil Calman – Institute for Family Health – President & Cofounder
(Inaudible.)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. Just that they have that recorded.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So there's no requirement that it be every time.

Neil Calman – Institute for Family Health – President & Cofounder
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Art Davidson – Public Health Informatics at Denver Public Health – Director
But I think it's important to remove this 65-year-old limit there. We started with the two-year-olds, and I can't remember why we did that.

Christine Bechtel – National Partnership for Women & Families – VP
It might have been a copy and paste.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It might have been a copy and paste.

Deven McGraw – Center for Democracy & Technology – Director
And the other measures, many of them are appropriate for kids, right, like BMI and height and weight.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, sure. So the issue there was structured data, so the idea, you can't record the growth chart as structured data where they fit on the growth chart. I'm sort of reading between the lines of why they said it this way. Even though the vital signs include height, weight, blood pressure, BMI, and growth charts, the measure is 50% have height, weight, blood pressure as structured data. So I'm guessing it's because there was not an easy way, at least right now, to have growth charts to appear as structured data, i.e. where they fit on the growth chart. BMI is a calculated measure anyway. I like Christine's reason for why 65 appeared there, because I have no idea right now … when you start with Excel, when you start, it starts putting in the rest of the stuff, and I must have put enter.

Deven McGraw – Center for Democracy & Technology – Director
Yes. I mean, I don't know why we wouldn't just think at least for now … percentage.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Eighty percent.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. The next one is smoking status, and the measure is that over 50% of the unique patients' whose data are in an EHR equal or older than 13 years old have a smoking status recorded. So a thought was just to raise that.

Christine Bechtel – National Partnership for Women & Families – VP
I think that's good. I think this is one where depending on the quality measures that we end up with, it may be … easier because I think the quality measures that we have in there now actually require or you have to know the smoking … compute the measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Let's keep in mind this pruning because pruning is good. Okay. We implement one … rule that went, you know, we talked about five, or we talked about some amount, and then it came to five in the proposed rule, and now it's down to one.

Christine Bechtel – National Partnership for Women & Families – VP
Where are you?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Wait. Before you … smoking status was just raised.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right. The first one was stage three is 90% reasonable.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think … earlier discussion, I mean, 90% seams reasonable. We had some discussion around secondhand smoke for pediatric patients as well. That dropped out from our final recommendation to ONC. I just wonder if we should bring that back for pediatric caregivers.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It could be a quality measure, but we'd have to capture the data … what threshold. That would add another ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
There's a standard now for capturing this smoking status. Is that included?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
He's talking about secondary smoke though.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Isn't it kind of, couldn't that be broadened?

Deven McGraw – Center for Democracy & Technology – Director
Maybe.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Included in the standard.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, so the EHR vendors would have to have fields to capture other people in the household.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I wasn't going to capture them. I was just going to indicate there was secondhand smoking.

Art Davidson – Public Health Informatics at Denver Public Health – Director
It's something we could ask the standards committee if they have a recommendation about that. It is a risk factor for kids that they live in a home where there is secondhand smoke.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It certainly is. Going back to two things: one is, we're not a comprehensive EHR certifying body, and the other is that we're not covering the entire spectrum of health issues.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. It just seemed like smoking status, you could expand that to include at risk for secondhand smoke or something as a status indicator because it's a status indicator of are they exposed to smoking …. That was kind of where my head was at. So you had that data as opposed to adding new fields or new people or anything like that. So I think the question, you could ask the question.

David Lansky – Pacific Business Group on Health – President & CEO
I think it's a valid question to pose for the quality measures workgroup. They may or may not put it under the population health category and see if they want to consider it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good. Both of these measures, both the vital signs and smoking status, where do we want stage two to be in terms of threshold?

Christine Bechtel – National Partnership for Women & Families – VP
Ninety percent.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Ninety percent.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Ninety for stage two?

Deven McGraw – Center for Democracy & Technology – Director
Yes. They've got 50% already. You've got 50%. That's vital signs and smoking status. How hard can that be? I don't mean to be flip except ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's what else do we put in the stage with it, I guess. I can't argue, but ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now this does apply to—it would apply to specialists as well.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Well the rule says EPCC, no patients, age two or older who believe that the vital signs have no relevance on their scope of practice are excluded. So there's an exclusion for specialists already on the, not on smoking, but on vital signs. But if we go to 90%, are we forcing providers who, like if you come in, you're going to force people to exclude themselves because they don't make 90%, but they really would have been at 80%. That's the only thing I worry about. Dermatologists, do they exclude themselves? Other people who are borderline who might not have, but will because we make it too high, that's my question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's only that they have this present at any time, correct?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The current measure just says has one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Has one. If we go with being a little lenient.

Deven McGraw – Center for Democracy & Technology – Director
…80%, that's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think she's saying 80%.

Deven McGraw – Center for Democracy & Technology – Director
If this is up to me, I want to use that … in a couple other places.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How do others feel about stage two?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Stage two on vital signs …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Vitals and smoking.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We're a little different from each other.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Vitals?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Smoking is a little bit easier in some ways. We don't want to make unnecessary rules either. Vital signs ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Is there a measure around this? I always come back to some of this data we're going to have to capture and keep current to get good measures out. To do clinical decision support, I have to have vital signs, but so much of this is just a byproduct of having to implement the system to be able to ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There is of course clinical quality measure on smoking.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Deven McGraw – Center for Democracy & Technology – Director
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So 80% for vital signs stage two and three, three staying at 80% because of there are these exceptions, and then smoking, do you want to do it staged 80%? I mean, it's kind of arbitrary what we do here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We could certainly put it this way and then we'll get feedback, both from the committee and from the public, so it's not the last word. It's just getting on the drafting table. CDS rule right now it's on CDS rule, and it's not defined what CDS means. The reason I put in my suggestion there the EG, here's the thinking that CDS really you're trying to influence the ordering behavior and making sure people don't overlook things. How they do that may depend on whether it's the system or local culture. There are many ways to skin that cat. I think we want to make sure that the systems have the capabilities but not prescribed what's done: one of this, one of that, and one of that.

By putting the EG, what we signal to the standards committee is we're suggesting they come up with criteria to certify the EHR systems that they can do reminders, alert. What I meant by colored choices are literally it could be colored in terms of saying these ones in blue are part of the evidence-based recommendations. But ways of making the right thing easy to do, that's what I meant by colored choices. So you can order anything, but if you order from this order set, the ones that are either colored or so indicated, these are the evidence-based orders. Those kinds of ….

Deven McGraw – Center for Democracy & Technology – Director
People get that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So there are lots of ways people can do that, and we're just trying to suggest to the standards committee, can you make sure that they have a range of tools available to the providers, and that goes into the certification criteria so that products are capable of doing different kinds of decision support. Local providers decide what's most effective for them in their workflow, and we get the net good out of it. How does that sound as an approach?

Tony Trenkle – CMS – Director of OESS
I have two reactions. One is, what does the word —use" mean in this context, and back to the issue of turning things off and so on, and not setting the bar so low that it's trivial. Then secondly, I'm thinking about whether it's possible to tie this to the quality measures function. I can't imagine how, but in an ideal world, if the user has the option to define which CDS to implement or high priority health condition, and we use this raise improve performance, the complement to that would be having—they would also pick a quality measure from the list that evaluates changes in performance.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. That's what that phrase is supposed to be.

Tony Trenkle – CMS – Director of OESS
We haven't thought about the quality measures as being that … or flexible, but it's worth thinking about.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we already have menu sets, and the notion is that the priorities, we've already said priorities are local. They can be state-based. They can even be … because smoking may be a big thing in one area, and not in another. Diabetes, the same thing, there's all kinds of ways in which they are local to a community, so we don't want to pin them down. They get to choose the high priority conditions, and then naturally they want to apply the CDS that would address those in the most effective way for their environment.

Tony Trenkle – CMS – Director of OESS
The Gretzky Report has a set of —leading conditions" where they picked off a dozen or so conditions as potential targets for priority quality measurement. We could work back from that list.

Deven McGraw – Center for Democracy & Technology – Director
I like that.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Tony Trenkle – CMS – Director of OESS
Is there a CDS that fits at least some of those 12 conditions, which we then pair a quality measure to a clinical decision category?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Why do we have to be prescriptive?

Tony Trenkle – CMS – Director of OESS
I'm only thinking about defining a menu that's tractable to our process and if we say it's wide open, then every subspecialty can come up with an esoteric rule they may think is very important. We don't have a complementing quality measure. We don't really know if they're improving performance.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's going to be pegged against a high priority health condition that are defined somehow.

Tony Trenkle – CMS – Director of OESS
That's what I was getting at.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. It's either it's you may choose the quality measures that address what the secretary says for this year or next year or these five years are high priority. Then from that set, they need to approve upon these things, and they need to apply rules to that. But I think we're saying the same thing, right? The only potential difference is whether we prescribe either a pairing or the leading condition.

Deven McGraw – Center for Democracy & Technology – Director
Paul, you're waiting for the secretary to prescribe them, which should happen in the next, I would hope, six months based on the national quality strategy. Is that what you're thinking?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Someone other than us.

Deven McGraw – Center for Democracy & Technology – Director
Well, if it's not the secretary, then I would say why not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. The secretary would declare the nation's high priority conditions.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The quality measures would track those.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And it's in the best interest of the provider organizations to use the tools to get there.

Deven McGraw – Center for Democracy & Technology – Director
I think the only thing, I'm not opposed to setting, to following some national priorities here, but I think we need to continually think about putting some flexibility in here for local priorities, and that will also help us with some of these specialists who still don't see themselves in this program because we've stressed to date measures that are sort of crosscutting across a number of specialties. But if OB/GYNs are working on maternal morbidity, and that's not one of the 12 high priority conditions, then it's hard for me not to want to encourage some of that. Obviously if we leave it wide open, and we end up with things that are all over the map, that's an undesirable set of circumstances as well. So I'm wondering if there is some sort of approach in the middle where there's pursuit of national priorities supported by what we're doing, but we're still leaving some flexibility. Maybe that's a core option type of scenario that was used in stage one that we might be able to borrow; build upon going forward. It just feels very top down in a way that I'm a little uncomfortable with.

Christine Bechtel – National Partnership for Women & Families – VP
It's almost like three, implement three rules related to national priority health conditions and/or implement three related to local priority conditions.

Deven McGraw – Center for Democracy & Technology – Director
Yes, or you have to do at least one national, and you have to do three, and you can choose them all from national priorities, or you can vary one, or you can vary two, or you can vary all three.

Christine Bechtel – National Partnership for Women & Families – VP
It sounds like stage two.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, I just want to encourage. I think the feedback … some people just get it, but the more you can be specific, it will really help in this space and, I think, exactly what you just said: some number and then some local variation on that, and give them some choices there.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I'd like to make maybe a recommendation here is that one of these rules might be related to the population and public health outcomes we're anticipating. So CDS could be related to immunization forecasting and what a kid or an adult should get in the way of a shot based on some public health recommendation or that the provider based on either receiving a lab test or ordering a lab test automatically reports to public health a potentially notifiable disease or something like that. So maybe we could do this menu of items, not to say which one, but one of them might be more directed toward public health as part of the CDS.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Are we sure we want to do this, or do you want to just put this in certification to make sure they have the tools? The question is, do we have to enforce use, or do we …? This is the first discussion we had today was, do all these other things we're doing force them to use them? Do we need to tell them they have to use it?

David Lansky – Pacific Business Group on Health – President & CEO
Yes ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's in certification at the very least.

David Lansky – Pacific Business Group on Health – President & CEO
I tilt toward a fairly aggressive posture on this one because I think CDS is, in effect, the end game of this entire federal investment.

Deven McGraw – Center for Democracy & Technology – Director
I do too.

David Lansky – Pacific Business Group on Health – President & CEO
In terms of top down, I'm not too uncomfortable with top down on this one because this is where the federal investment is going to pay out, and this is the government saying we're going to give you all the money. We need to see you're making an impact. I like Art's suggestions. I think having an impact on a couple of these national health priorities, including the public health priorities, is a way to say to the public, we spent your $30 billion on something that makes a difference, and we are implementing something nationally to drive performance on vital health indicators of the public. Even though there may be other priorities, they absolutely positively should invest in achieving those, but I think if we are only having three or four rules out of the $30 billion investment, we should be able to say these are national priorities and, in addition, do whatever you want to do to improve local priorities.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's another …. So there's a minimum set, basically. There's a minimum set of addressing the national priorities. Again, it's federal dollars. That's a fair point. But nobody is preventing anybody from doing anything.

Deven McGraw – Center for Democracy & Technology – Director

Right. Let me ask Charlene a question. If there's a local priority on CDS, do we have enough in the meaningful use CDS requirements to insure that the systems would be able to handle that functionality?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think so.

Deven McGraw – Center for Democracy & Technology – Director
Okay. In that case then.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think what's stated there is reasonable.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The biggest issue for the vendors is where you can add some specificity and guidance, so they don't have to interpret, where do I go to find this?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That helps.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We'll add specificity on alert reminders, the different kinds. But the whole reason for putting a list of any kind here is to trigger the standards committee to trigger the certification criteria because we want to make a set of tools available.

Deven McGraw – Center for Democracy & Technology – Director
Right, but the certification criteria would have to be for CDS. I mean, that was my question. In order to accommodate ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
CDS … and it would encompass ….

Deven McGraw – Center for Democracy & Technology – Director
…the local priorities that people want to do, we don't want to have them faced with, well, the systems can't actually make this happen.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
CDS encompasses order sets, clinical decision support, pulling a panel report of how you're doing. Again, it can be a lot of stuff there to help you, and I think the bigger the more the better is what you're thinking of. Most systems have a lot of those types of tools in place today, but they need to know what populations, what group of patients they're managing, either at a panel level or at a population level. Then they'll apply those tools, and you want them to be able to apply them in different ways.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What George has written is that for stage two there be four … four specific high priority conditions. Do we want to pick a number for stage two and three? Or is it implicit in your quality measures? Once they have to report a certain thing, that may be….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right. Some of it is going to ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What we're trying to do with this one is get the functionality into the EHR in a certified way.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And I think you'll get pushback on this because they'll say, what do you mean?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. We'll have to come back for vetting the next call. We'll enumerate some of these CDS functionalities.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. I would amend the text maybe for two or maybe three to reflect Art's suggestion that including public health or including at least one public health outcome or whatever you want to call that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fair.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Maybe you'd want to put that in stage three, and then … stage two will depend on what we end up with ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, and the reason you might do that is because I think people are a little uncertain whether by 2013 we're really going to have the public health infrastructure—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right, so definitely should be in stage three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
—laid out in all the states.

David Lansky – Pacific Business Group on Health – President & CEO
We hope for an earlier ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We can always hope.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I know ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We can always hope, but the economy isn't what it could be. Okay. The next one is a menu option, which is to implement drug formulary checks. I just throw it out as a draft, 90% of medication orders are checked against relevant formularies, or George proposed 80%, but something like that.

Christine Bechtel – National Partnership for Women & Families – VP
I feel like we're slipping a little bit on what we had talked about before, which is starting by figuring out what is it that we're trying to achieve here through drug formulary checks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's one of our few efficiency measures.

Christine Bechtel – National Partnership for Women & Families – VP
I agree. Yes. So backing up from that is the outcome goal that we're trying to achieve, just the checking. I'm not sure. I would rather see that as a stage two type of measure. I would rather see some cost measures from the quality workgroup.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We can so note that.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, we discussed that today.

Neil Calman – Institute for Family Health – President & Cofounder
And also … formularies spectrum of … like that in a format … used electronically. I know that's big for us.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It doesn't exist now.

Deven McGraw – Center for Democracy & Technology – Director
I didn't understand what he said.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think he was saying right now we do not have access to this.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So it's pretty hard for us to get there when a lot of us ….

Deven McGraw – Center for Democracy & Technology – Director
So SureScripts now works with RxHub.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They don't give us formulary information that's up-to-date. Think of right now there's a call for a national plan, health plan identifier. The complication there I each plan has so many products, and each product has the potential to have a different formulary. Just managing it, right now we can't even get them identified, the products identified, let alone try to figure out what the formulary goes with. So there's just a lot of work … so the providers really just don't have access to that.

Christine Bechtel – National Partnership for Women & Families – VP
You have that in stage three because the infrastructure isn't there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The infrastructure, right.

Deven McGraw – Center for Democracy & Technology – Director
I just went to the SureScripts SafeRx Awards yesterday, and those awards, in talking to SureScripts, are based not just on the number of scripts that are done electronically, but formulary checks and drug/drug interaction checks. So I think it would be good to just, as a side note, to sort of check in. You all have personal experience with this, so it doesn't work well from your perspective. So I think it's important to keep that in mind, but we should check on where that's headed and what the projections are for getting that fixed.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Did you change stage two, I mean, I think for stage three …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so stage two, 80% probably is high. It's only two years away.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I mean, we really don't need to know the dependency on the availability, right, and how that is scattered by market and all that type of thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Or by plan.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. We … after this, I mean ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This gets the providers in the spot they just can't do anything.

Neil Calman – Institute for Family Health – President & Cofounder
The community help centers develop their 340B programs, and the centers have the ability to develop their own formularies, so I don't even know where stuff like that would get loaded and how that would be accomplished. I think the mechanics of this are pretty difficult.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. By stage one, we're trying to get the capabilities in EHRs. Stage two, we're trying to reach out, but just knowing that we're not going to get a full set and hoping towards stage three that we're right there. Then that's from a structural point of view, but then the quality group will, the quality measure group will help us define what the goals are in terms of ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And this is a menu item too, so ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, at least in stage one. Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's a menu item. They can defer to stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct. But stage two, the implication is that it would become ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's required.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Required.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We'll get … I think this one will be challenging for all those other sundry reasons.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But in the hospital, you know who your formulary is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's embedded, so that's …. But in the ambulatory setting it's ….

Deven McGraw – Center for Democracy & Technology – Director
Can we come back to the deferral? I guess I have a question for Tony just to make sure I'm understanding this because until Charlene said that, I wasn't tracking or wasn't thinking of it. Do we have potentially a situation where somebody can defer implement drug formulary checks to stage two and then the stage two measure is 50% checked? So if somebody defers the drug formulary checks, then in stage two, do they have to simply implement, or do they have to do 50% if they deferred it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Fifty percent.

Deven McGraw – Center for Democracy & Technology – Director
No, I'm not so sure.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It has not defined, right?

Deven McGraw – Center for Democracy & Technology – Director
So if you defer it, you have to meet whatever the next measure is in that area. You don't have to meet the stage one measure. You have to meet the stage two measure if you defer it?

Art Davidson – Public Health Informatics at Denver Public Health – Director
No.

David Lansky – Pacific Business Group on Health – President & CEO
If it's your time to do stage one, then you stay in stage one. But if you're in stage two, you do stage two. If it's not a stage two menu item, then you have to do the 50% even if you deferred it before.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

David Lansky – Pacific Business Group on Health – President & CEO
That's why ….

Deven McGraw – Center for Democracy & Technology – Director
…crazy ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
No. Yes, I hear you. You can defer it as a menu item for stage one. If we make the menu items mandatory in stage two, as we've signaled in the reg, then you would have to meet whatever percentage we had for that for stage two.

Deven McGraw – Center for Democracy & Technology – Director
For stage two.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right. You've already received an incentive payment for having met stage one. You're not a new ….

Deven McGraw – Center for Democracy & Technology – Director
Because this is a flag, this could affect our parsimony idea too because if you deferred something that disappears out of stage two, do you still have to meet it? Do you see what I'm saying? So let's say that we decide that I'm just going to like pick one. Recording vital signs, we think you don't have to do that anymore in stage two because you're going to have to do it in order to do quality measurement and

decision support, and so we say for parsimony, let's eliminate that. But if you deferred that from stage one to stage two, but in stage two that no longer exists, what do you do?

Tony Trenkle – CMS – Director of OESS
You didn't defer it from stage one to stage two. You just didn't do it in stage one. There's no such thing as deferring. It gets defined in every new regulation we come out with, so there's no such thing as deferring. It's, you don't have to do it as one of the menu items. You pick which menu items, and you can defer up to five. But the issue is what the criteria will be for stage two won't be defined until we go out in rulemaking.

Deven McGraw – Center for Democracy & Technology – Director
That's helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…so 20 might be right or 30 or something like that. if we want to put any percentage, it has to be low.

Tony Trenkle – CMS – Director of OESS
In an implemented site now in one of your programs, given the need to have external data available, what is the current level of achievable formulary checking?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There are two things working against you. One is the lack of availability of maintained formulary from the payer. The other is being able to keep up to-date-on the products that a patient is on. Both of those work against you, but it's tough.

Tony Trenkle – CMS – Director of OESS
What do you think your level at Palo Alto is now for formulary checking correctly, valid?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We ended up picking some of our high volume plans, and just sort of writing special rules for that. I don't know what the total percent is, but I know ….

Deven McGraw – Center for Democracy & Technology – Director
So is the measure we're discussing 50% of medication orders are simply checked against a formulary, and the result of that check may be the formulary doesn't exist, or is it something else?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the spirit is that it's actually checked, and you get feedback on ….

Deven McGraw – Center for Democracy & Technology – Director
Against some existing formulary?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Now they … they could be internal or external, and since you might describe us as internal because … some of the high … externals. But these are workarounds because we do not have the infrastructure in place to track either the payer or the patient.

Deven McGraw – Center for Democracy & Technology – Director
George is saying 50% too high, maybe it's 30%. Is that what you're saying.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, I worry about 30%.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. I think this should be eliminated. I mean, this is exactly what the industry and what providers are screaming about is that the idea of putting something in for which there's no mechanism for them to

actually do this. I think we should eliminate it until there's a mechanism in place or signal it for stage three and put nothing in stage two. I just don't think it makes sense.

Deven McGraw – Center for Democracy & Technology – Director
Or leave it for hospitals.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
They can meet this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm somewhat sympathetic to that.

Neil Calman – Institute for Family Health – President & Cofounder
Leave it for hospitals and not ….

David Lansky – Pacific Business Group on Health – President & CEO
Or we could just make the current rule mandatory.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, make the current rule mandatory, exactly, because the current rule is pretty flexible and could be achievable.

David Lansky – Pacific Business Group on Health – President & CEO
Or move it to core, I guess, is what I'm saying. Move current rules to core.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
What's the current rule for ambulatory?

Deven McGraw – Center for Democracy & Technology – Director
Implement ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Basically that you implement. If you choose, it's a menu option. If you choose, you should implement a check against a formulary, which may be internal or external.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
They have to enable the functionality and have ….

Deven McGraw – Center for Democracy & Technology – Director
I think that's good.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…one internal ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. I think that's fair. That's flexible. We certainly, until we prune it, unless we prune it, it should at least track stage one.

Deven McGraw – Center for Democracy & Technology – Director
We have a parking lot item to follow up and talk with the industry about the trends in this area, what's possible today, and what the gaps are.

David Lansky – Pacific Business Group on Health – President & CEO
And whether there's an efficiency measure on the quality measurement side that would incent adoption of this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's up to you.

Neil Calman – Institute for Family Health – President & Cofounder
…the menu options.

David Lansky – Pacific Business Group on Health – President & CEO
We're not saying it's an option. We're saying it becomes required in stage two, Neil.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But you get your infrastructure in place then.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
What's the efficiency measure? That the patient doesn't have to come for a second prescription or something like that ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There's efficiency measures already, percent of when generic is available.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In fact, that was our efficiency ….

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was one of our few efficiency measures.

David Lansky – Pacific Business Group on Health – President & CEO
This is not generic or brand. This is, I go to my pharmacy, and they tell me my plan doesn't cover it, so I've got to go back to the doctor.

Deven McGraw – Center for Democracy & Technology – Director
Right.

David Lansky – Pacific Business Group on Health – President & CEO
That's the efficiency we're fixing with this rule.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. We actually had the generic in our original, which is already a fairly widely used measure.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I mean, the positive on these is that the vendors are certified to the menu items, in addition. So if you go to stage two, there's a glide path to get there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right. No, that's good. That's a good point. The next one is the advanced directive, and the current one is that 50%— No, let me see how is it written?

Deven McGraw – Center for Democracy & Technology – Director

Sixty-five plus hospital only.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. For hospitals, for the patients over 65 years old, 50% of those unique patients have an advanced directive recorded.

Deven McGraw – Center for Democracy & Technology – Director
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No?

Deven McGraw – Center for Democracy & Technology – Director
They have the presence of one recorded.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's the presence of one.

Tony Trenkle – CMS – Director of OESS
Right.

Deven McGraw – Center for Democracy & Technology – Director
Right, so it's just, is there one or not.

Tony Trenkle – CMS – Director of OESS
It's an indicator.

Deven McGraw – Center for Democracy & Technology – Director
It's not what it is.

Tony Trenkle – CMS – Director of OESS
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what I meant, yes. Have recorded it.

Deven McGraw – Center for Democracy & Technology – Director
Right. But see, this is, but it's a yes or a no. It's not, well, what is the actual content of the advanced directive.

Tony Trenkle – CMS – Director of OESS
Right.

Deven McGraw – Center for Democracy & Technology – Director
…problem.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. What I had in the proposal is 90% have a recorded advanced directive.

Deven McGraw – Center for Democracy & Technology – Director
The actual thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The actual thing, the indication.

Deven McGraw – Center for Democracy & Technology – Director

Right, which I think is better.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
As the future state.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right now it is only the present.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And we need a standard, what it is, and all that stuff.

Deven McGraw – Center for Democracy & Technology – Director
Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So it could exist, it probably exists on paper somewhere.

Deven McGraw – Center for Democracy & Technology – Director
Yes. I think stage three has to be EP and hospital, obviously, and I think we should back up from that into stage two to say there needs to be something in the EP space.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can you indicate that, George? So the current proposal on the table is stage three for both providers and hospitals that for 90% of patients over 65 or over have the advanced directive recorded in the EHR.

Tony Trenkle – CMS – Director of OESS
Yes. Paul, this is an area that has gotten a lot of interest from a number of people, and it would be helpful if the committee could look a little deeper into it and then see what seems feasible because we did get a number of comments, and there's been interest from a number of groups and some members of congress as well, so it would be helpful if you could take a look at it.

Deven McGraw – Center for Democracy & Technology – Director
I think that's fair. I think one of the things that we should also look at is whether it should be 50+ and not 65 by stage three.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We're saying that 90% of patients have to have an advanced directive recorded?

Deven McGraw – Center for Democracy & Technology – Director
And … exception ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Or requested or what?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It has been discussed, so the goal is that we've discussed this with all patients. Then if they have one, we record it, so it's visible to the providers.

David Lansky – Pacific Business Group on Health – President & CEO
And accessible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And accessible, right, but there's no forcing. Anyone can, but the fact that we have recorded either the absence because we've discussed, and they don't have one, or if they have one, we make it very accessible by people. That's, I think ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, that clarity.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Would you say that that would be inconsistent with some of the wishes or others?

Tony Trenkle – CMS – Director of OESS
No, I think that's consistent, and there was even some on the ambulatory side who wanted to look into that as well, so yes. I think you've ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Tony Trenkle – CMS – Director of OESS
…separate issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Deven McGraw – Center for Democracy & Technology – Director
I think the goals are the right ones, but when it gets articulated as percentages of patients, I think we run the risk that people will say we're forcing this on people. Thou shalt have an advanced directive by age 65.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If we were very clear on, it has been discussed, and the results are recorded and accessible, that's the goal.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Why don't we just add that, have recorded, a discussion or the results of advanced directive discussion so that it's clear that we're not trying to get people to have one any more than a discussion?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we want to record the results of the discussion, which can be no, I don't have one, and I don't want whatever it is.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now we need to be very careful in the wording and make it very explicit, not assume that these words capture, so the … is we've given people the opportunity, and it is clear to people what exists or doesn't exist.

Tony Trenkle – CMS – Director of OESS
Paul, it might be helpful to get some testimony from various groups on this.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. I think the same issue, a standard doesn't exist for this. What is it? As soon as we—the presence or absence is one thing, and then there's probably variation of what that might look like in different states. Some baseline would be, I mean, the way forward if there could be at least some baseline, so at least now we know whether there's one there or not.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And then, could we get started on a glide path because there's going to be complexity out at this other end of it.

Deven McGraw – Center for Democracy & Technology – Director
Yes, most of them are written on paper.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…fifty.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, in whatever form, right?

Deven McGraw – Center for Democracy & Technology – Director
Yes, and they're variable, yes to this, no to that.

Tony Trenkle – CMS – Director of OESS
Right.

Deven McGraw – Center for Democracy & Technology – Director
There's no single way to do it, so is it possible …?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But there could be a couple key indicators or some steps.

Deven McGraw – Center for Democracy & Technology – Director
Yes, or a PDF file.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Which is fine.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That would be okay too. I think like that. I mean, if you're clear and say, okay, you've got to store the PDF of the outcome of the conversation, we could deal with that too. But you ultimately want to get to probably it contains a few elements.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The first part we're trying to solve is we don't even know how to act on the patient's wishes when they exist. That's the first problem we're trying to solve. Then we can worry about how can we even be more informed at every point in the decision, which then means it has to be structured and fit into … but first we've got to know how to comply with what already they wanted.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Is there anything we can put in stage two that gets to that goal?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think Tony ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…what we've got?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We need a bit more counsel on what are the issues that people are raising, so I think, because stage two is the next one, and we don't want to mess up ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
I thought that there was a recommendation in stage two, at least expand this beyond just the hospitals. Isn't that what I heard you say, Tony?

Tony Trenkle – CMS – Director of OESS
No, I didn't say there was a recommendation in the regulation. I said some of the groups who've talked to us have made that recommendation, so that's why I'm saying, I think some hearings and some testimony might be helpful to get some differing groups out because there is some ambiguity there that would be helpful to get some clarity in terms of what the baseline is and what some of the key issues are. Then, of course, there are the issues around various state statutes that impact us as well.

Deven McGraw – Center for Democracy & Technology – Director
And ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And providers and hospitals may be just storing the PDF anyway if they have it, or what are the obstacles to getting it? So that would be interesting to find out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. We'll do further work on this, but some of the spirit is, let's see if we can make patients' wishes as actionable as we can.

Deven McGraw – Center for Democracy & Technology – Director
And it may be something that we ask particularly in the RFI for feedback.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Exactly right.

Deven McGraw – Center for Democracy & Technology – Director
I'm not sure if it's a testimony issue as much as it is really in the RFI, but I think people probably need something to react to in stage two, so we might just signal, consider expanding to ambulatory, request input about age, limits, and interactions with state law. But I think we have to have something in that stage two box.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Tony Trenkle – CMS – Director of OESS
Yes. I think the issues that we heard were the ambulatory, the age, and then the question about how much information you could allow to be seen, and some of that does get into state laws, I believe.

David Lansky – Pacific Business Group on Health – President & CEO
We could also, as we did for the previous topic, move the current measure to core. It would be a stage two solution without changing the threshold.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right, but it is core.

Tony Trenkle – CMS – Director of OESS

We've already signaled that direction that we haven't—

Deven McGraw – Center for Democracy & Technology – Director
Yes, I think ….

Tony Trenkle – CMS – Director of OESS
—qualified it in a reg, but we have signaled it.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
…move the current measure to apply to ambulatory or EH?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, we can go ahead and do that.

Tony Trenkle – CMS – Director of OESS
Yes.

Deven McGraw – Center for Democracy & Technology – Director
And then just signal say in there, move current measure to ambulatory or expand current to ambulatory. Request input on age limit or age thresholds and interaction with stage law so that people know the three things we really want some input on in the RFI.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We're talking about dentists though, as we go to … do you want to go to …?

Deven McGraw – Center for Democracy & Technology – Director
Yes. This is part of what we want input on because a lot of people are saying yes. Maybe you put that as a fourth thing, application to specialists.

Art Davidson – Public Health Informatics at Denver Public Health – Director
But even in the core measures, can't you say that this doesn't apply to me?

Tony Trenkle – CMS – Director of OESS
Yes.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So we have that out still. I think we're just trying to move this into the EPs.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next one is lab results, which is a menu item. I think a lot because of the infrastructure, so right now it's written as lab results for things that are ordered in the EHR that 40% of them return back as structured data. Did I say that right? Then stage three, a proposal—where did it go? Can you have them toggle over to the right?

Christine Bechtel – National Partnership for Women & Families – VP
Stored as structured data ….

David Lansky – Pacific Business Group on Health – President & CEO
…just wanted to make sure everyone knew there was a hearing ….

Deven McGraw – Center for Democracy & Technology – Director
This is 100%, right, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, see, there's always the reference lab, the one of kinds of labs where it's always done.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's why it's not 100. That's all.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Christine Bechtel – National Partnership for Women & Families – VP
The public hearing was bidirectional interface.

Deven McGraw – Center for Democracy & Technology – Director
If this is a menu item, I know we really wanted to move on this in the information exchange workgroup as well, and so certainly moving it to core, and whether there's a different threshold beyond what's in the menu, I'd toss out there. But then, ideally in stage three, this stuff gets routinely stored in a structured way. This is not one where there's disagreement over the standards. That's very clear. It's critical that it be standardized.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Clearly, having a strong signal that this is the expectation, this is where a lot of the data will lie, so we agree with the stage three draft there, 90% instructor …?

Deven McGraw – Center for Democracy & Technology – Director
Yes, you actually don't have a percentage in here, unless I'm on the wrong line.

Christine Bechtel – National Partnership for Women & Families – VP
The printer cut it off. It's on the ….

Deven McGraw – Center for Democracy & Technology – Director
Sorry. I've got to put my glasses on to see ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Just to point out, there is the hearing recommendation, which is a bidirectional interface. As we talk about stage three, I don't know if you want to incorporate this, which is further than stage ….

Deven McGraw – Center for Democracy & Technology – Director
Yes, I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We used to, in our original matrix, we had that as well. This is the ordering.

Deven McGraw – Center for Democracy & Technology – Director
Yes. That's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. In stage three, we definitely want that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It'll be a bit of a challenge to get 90%, but at any rate, so stage three, lab orders and results. In stage two, the default would be to just make it core and do one. Do we want to include orders? Two, do we exchange the threshold? Orders would be a big move.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, and what's the status of the order standard? I thought that was the gap that we had.

Deven McGraw – Center for Democracy & Technology – Director
No, the standard is the same.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
For the orders? It's not the same as the results standard. It's a separate standard because the ordering process is different.

Deven McGraw – Center for Democracy & Technology – Director
I'd have to dig that stuff out.

Christine Bechtel – National Partnership for Women & Families – VP
…adding ….

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think it's a critical gap that needs to be—so I think you need to just look at the current status of that standard, and if we could get to both, but it's always been a challenge on the ambulatory side.

Christine Bechtel – National Partnership for Women & Families – VP
Charlene, are you saying that the standard is not in a place where it can be fed into the certification process in time for 2013?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's hard on the order side.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's hard. Most implementations have done the hard work of mapping at least the important ones for themselves, which is unfortunate, but ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. I think we need to push on the standard. You want to ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And implementing the standards because the smaller practices have to deal with all these labs. They don't have the same control.

Tony Trenkle – CMS – Director of OESS
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Even our own health system lab … a challenge, which is why I can totally appreciate the standards and the implementation.

Christine Bechtel – National Partnership for Women & Families – VP
I wonder if we should pair this with a recommendation then that talks about really accelerating progress on that and maybe go back to some of the IE … IE workgroup.

Deven McGraw – Center for Democracy & Technology – Director
Yes. I'm trying to … I've got like 623 messages in my information exchange archive box. I think let's make some notes about checking to see what the IE workgroup recommendations were on this because I think we're trying to push the bar higher, and let's try to use those.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And standards is going to use the output of today's meeting and this month's meeting to work on this, so clearly ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I just think bidirectional and stage two is going to be really tough. But I don't disagree. It should be where we're ending because you want bidirectional. In fact, how do you expect me to do all this without bidirectional, but it's really hard.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
As a placeholder for stage two, making it core, do we want to do anything about the 40%? Once you get to 40%, you're probably on your way anyway. Nobody stops.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'd raise the bar.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Raise the bar to 60 or something?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't know what the number is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Once you get clinical lab, you're just going to be past some threshold already, so it sort of doesn't matter what the number is. Good.

Neil Calman – Institute for Family Health – President & Cofounder
It does for people with multiple laboratories that they use.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. I'm guessing most people, even the smaller practices, use one source for clinical lab, which is the bulk of the test results.

Neil Calman – Institute for Family Health – President & Cofounder
But I don't think that's really true because the managed care companies have exclusive contracts with one lab or another, so you'll find three or four lab boxes outside of every office.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So we could rely back on the 40%, which is where CMS decided that was the balance.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. I think that's probably where we should be.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is that fair for folks, 40% for the lab results? It's just making it core. Yes, making it core basically. The next one is generate patient registry lists. It's a little bit of a dinosaur. We thought we were onto something with registries. Then we had testimony from the specialists and recognized that registries may not be the ticket into specialists, certainly not very many. So I'm wondering if this is one of these legacy ones that we may not, I mean, it's going to be subsumed by a whole lot of other things.

Neil Calman – Institute for Family Health – President & Cofounder
I would agree.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This is huge too because, as you go down that specialty, then it's another system you have to have in place and another application, so it gets pretty ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In order to accomplish anything, you're going to have to have the capability of generating lists from your EHR. This additional prescription, I'm not sure gets us anywhere, and can almost mis-signal what we mean actually.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Now the feedback, and I don't want to add more, but the feedback we got from our customers about the list is they want to know who that panel of patients is that they're taking care of, and they want to manage that list of patients, and then they can improve their quality. I don't know whether that's—but that's kind of like, we've got the big quality measures, but that … piece to help them really improve compared to other providers that are on their panel and that type of thing. That's the kind of feedback we get in terms of the NHIN.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There are a couple of voices that are speaking to use the … to prune this particular item. What do other people think?

Christine Bechtel – National Partnership for Women & Families – VP
I think I generally agree with that, except I have a question about is there any way that this is particularly applicable to specialists, for example? I don't know that. It just seems to me we had a lot of discussion about specialty … hearing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, there's a lot of discussion on specialty for a very few number of specialties and very few registry operators. So it turns out that it doesn't have a broad scope, and then there were issued raised in the hearings when we talked about them.

Christine Bechtel – National Partnership for Women & Families – VP
And depending on the quality measures for those particular specialists, they're going to naturally want to use those or not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
People are going to have to create selective lists in order to manage their panel and manage their quality in creating an extra ….

Christine Bechtel – National Partnership for Women & Families – VP
Couldn't you just take registry off?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. Why create this?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm okay with taking stuff off too.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think this is very analogous to decision support.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
There's a tool in the EHR, which you could improve care with, and we want them to use it, but do we have to specify it as an objective or not? It could actually just be a form of decision support and roll it into there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We actually have it. I think it's in care coordination. We have the function creating patient lists. I believe it's somewhere.

Christine Bechtel – National Partnership for Women & Families – VP
I got feedback from folks ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
Where does that fall?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I thought there was another one.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
There's another one on specialists. I know we got that ….

Christine Bechtel – National Partnership for Women & Families – VP
That might have been the language that's actually in the rule, Paul, that you remember because I'm remembering the same way, which was condition specific or something like that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
But maybe somebody just shorthanded the registry thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think you're right.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, because we originally had it as manage chronic conditions using patient lists and decision support. That was what was in the original matrix that we did.

Deven McGraw – Center for Democracy & Technology – Director
Yes, that's where ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here it is under manage populations. It says generate at least— Okay. I think somebody shorthanded it. You're exactly right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Which one is it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The menu item is generate at least one list of patients by specific conditions for quality improvement, reduction disparities, or research … one or more reports. That's a menu item. That's fine, and we need that functionality. Calling it a registry just introduces a new concept that's probably unnecessary.

Christine Bechtel – National Partnership for Women & Families – VP
You're saying, Paul, keep what's actually in there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Keep what's written, right.

Christine Bechtel – National Partnership for Women & Families – VP
Which is this, but it's not the word ―register".

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Christine Bechtel – National Partnership for Women & Families – VP
Generate patient lists for quality reporting, research, and whatever.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And is there anything more that we need to—? The reason that's there is to make sure we certify that capability in the EHRs. I don't know that we need to do anything more from a … point of view.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Are you including this one, or are you …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. George, if you can edit the stage one final rule to say generate patient list, condition specific patient list, that would be more clear.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Patient specific?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Condition specific patient list. Then I'm not even sure stage three has to say anything more than having that capability because the action is going to be driven by the quality measures.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
As you get that high, then it's going to be high or the local ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
…problem.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The final one in this category is send patient reminders. This was one actually that we had proposed initially. It wasn't in the NPRM. Then it got put back in. This was saying ….

Christine Bechtel – National Partnership for Women & Families – VP
It gets reminders for prevention and followup.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Send patient reminders per patient preference, which means that they could get it in mail or paper, for preventive or followup care, and the measure is over 20% of all unique patients whose data is in the EHR that are either 65 or older or 5 years or younger sends an appropriate reminder during the reporting period. Now let me see if I've got it correct. The denominator for the 20% is all your patients in those age categories, and 20% of them then had to have received a reminder during in stage one the 90 days.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But you have ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Then I think that's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's what it says. It may be a little bit ….

Tony Trenkle – CMS – Director of OESS
If I can read the explanation, we've got the explanation. Let me look at it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

David Lansky – Pacific Business Group on Health – President & CEO
I can see the challenge of 90 days being ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, 90 days could be a problem for the first year. Let me go to the right page.

David Lansky – Pacific Business Group on Health – President & CEO
Have you ever seen that before?

Tony Trenkle – CMS – Director of OESS
Yes, a few times. Keep going.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The question is, in the end, stage three, if you use the same definition, that is the over 65 and younger than 5, then I think it's a little challenging, and so I think what CMS is trying to do is make sure that people don't have to count paper. Either you use the total patient population you have or some identifiable subset that applies to the activity. In this case, they're using the total population and then, of the total population, that's 65 or older or 5 or less, how many of those people should have received a reminder, preventive or followup care, in a year's period by stage three at least?

That's the question that's asked using their denominator definition. I just sort of picked a number. It seems like over 65, you're probably going to get one. Under five, you're probably going to get one as well for immunizations. It seems like most people could have received a reminder about something in that time period.

Christine Bechtel – National Partnership for Women & Families – VP
When we, with our colleagues in the consumer community, looked at the—I know when the draft rule came out, it was 50+. We essentially said it's really less about age and more about clinical appropriateness. I'm wondering if there is a way to recommend that all patients get a reminder, or some percent of all patients, regardless of age, get a reminder for either prevention or followup care because, remember, it's both domains based on what's clinically appropriate for them. Is that too difficult to constrain?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Say it one more time.

Christine Bechtel – National Partnership for Women & Families – VP
It's some percent of all patients, all active patients have one, I guess, and if I'm looking at yours, one patient specific reminder sent because it's based on clinical appropriateness.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And you're expanding the age group to all patients?

Christine Bechtel – National Partnership for Women & Families – VP
Absolutely, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Between 5 and 65, well then what percent? Would you have a low, high, or medium percent?

Christine Bechtel – National Partnership for Women & Families – VP
Let's get to whether we can do that or not. I mean, let's just call it 40% or 30% for the sake of argument right now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm almost ….

Christine Bechtel – National Partnership for Women & Families – VP
…prevention and followup, there is almost nobody who doesn't need to have an annual exam, flu shots, pneumonia shots, tetanus shots, right, because it's prevention and followup. Followup is, you've got to come back and do these tests.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In the age group between, well let me just say 18 and 50, there's not a whole lot that they have to do. When you threw in ….

Neil Calman – Institute for Family Health – President & Cofounder
For women, you have pap testing. You have followups for people who are on cholesterol medications. You need liver function tests. I mean, it may not be everybody. This may be a measure where you never get 90%. But I do think that including all age groups is appropriate because you really don't want people to not focus on things that need to be done in that middle age group because they're so focused on the young and elderly. So I would rather keep the percentage low and have everybody included.

Christine Bechtel – National Partnership for Women & Families – VP
The other alternative would be to say for clinically appropriate, at clinically appropriate moments because it does capture the fact that primarily it's an end between the ages of 18 and, let's call it, 40 that may not need as much preventive care, but they will need followup care. They should have preventive care.

Neil Calman – Institute for Family Health – President & Cofounder
But you can't do a denominator on that. I don't think you can do the denominator. I mean, I think it would be really hard to calculate the denominator.

Christine Bechtel – National Partnership for Women & Families – VP
On clinically appropriate?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, that makes sense.

Neil Calman – Institute for Family Health – President & Cofounder
You're going to end up with a mess on there.

Christine Bechtel – National Partnership for Women & Families – VP
What if we do 20% or 30% of all patients for a reminder or followup?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Have we defined what an active patient is?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, one of the dangers here is a description, assignment. I wonder if we could benchmark this with some current providers who are well established in this practice and say, across a population level, what is your rate of how many patients? What proportion of your patients do you send reminders to? Maybe subset it by these two or three age-based groupings. But also I think, again, the quality measures is a place to get at, if this is being done effectively, hopefully they're going to drive up their preventative measures on performance.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right. I mean, the other piece this falls under is it's part of the clinical decision support tools they're going to need because you link clinical decision support to the measures, so you're starting to work back from that, and that's one of the tools you're going to need to have in place be able to manage those conditions.

Neil Calman – Institute for Family Health – President & Cofounder
The other thing is, I'm not sure that, and I'm just ignorant on this, but do the EHRs have some certified fields or something like that that captures patient preference for reminders? If not, we're going to have to call that out right away.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't think currently they do.

Neil Calman – Institute for Family Health – President & Cofounder
So we're going to need to call that out because if we say per patient preference, which I think is a critically important part of this, we're going to have to make sure that people capture that information, and they need a period of time in which to capture it. So if it's in the certification for the next certification criteria, people are just going to be able to begin to capture that information. We would have to keep the percentage very low.

Christine Bechtel – National Partnership for Women & Families – VP
But it's already in this certification criteria because the criteria is per patient. But it is per patient preference, so in stage one, it's … per patient … and we think it's either 50+ or 65+ or whatever it is. So that should already be part of current certification ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
Would it be maybe going back to what Neil is saying that we have people record what the patient preference is. Is that something? I mean, if the EHR is capable of doing that, should that be something that we would like to see be used, the preference?

Christine Bechtel – National Partnership for Women & Families – VP
Or do they have to do that already because in order to meet the criteria on stage one, which is send patient reminders per their preference, wouldn't they have to record it?

Art Davidson – Public Health Informatics at Denver Public Health – Director
This was not in the core.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's not in the core, but it would have to be certified. So it is certified that we have this field available?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
If that's what the requirement is, it will be there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…it is, but I don't know ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't have that detail.

Art Davidson – Public Health Informatics at Denver Public Health – Director
What's…? I saw them this year or saw them last year, two years ago?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Here it is. It's per patient ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a fair question. One of the measures that's used is if you've seen the patient in the past two years … large practices use that, but that's not an industry standard or anything, so we have both the active patient, the active patient concept, and the attribution ….

Neil Calman – Institute for Family Health – President & Cofounder
For the active patient, my feeling is we should keep it as broad as possible because it's exactly the people who haven't come back that you want to do the outreach to. Saying anybody that's been in, in two years, seams reasonable to me.

Tony Trenkle – CMS – Director of OESS
The problem is a lot of physicians don't think they own the patient who they saw kind of randomly two years ago, and especially the specialists who may have seen them.

Neil Calman – Institute for Family Health – President & Cofounder
We're not attributing the quality of care to them in this particular measure. We're just saying do the outreach to them.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Neil Calman – Institute for Family Health – President & Cofounder
I think this is a much easier one for people to take a broader denominator definition on that says if somebody has come in to you who is a diabetic, and they're failing certain maintenance criteria, just get in contact with them. But to me, I'd rather keep this definition broad, and then when you get to the attribution for quality measurement, I think that's where you get a lot of pushback around making a more narrow definition of who owns the patient.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Like a pediatric cardiologist, what reminder should they be sending over the pediatrician is one issue. The other is we bring our kids for their appointment every year at their birthday. That's easy to remember, so I don't really want any reminders because we're already doing it right. I want a reminder if I forget to bring them on their birthday, so normally I shouldn't get any reminders during the year for my kids. Just because they need preventive care doesn't mean I should be getting a reminder necessarily.

Christine Bechtel – National Partnership for Women & Families – VP
But that would be a patient preference. No reminders is absolutely a patient preference.

Art Davidson – Public Health Informatics at Denver Public Health – Director
…Art, so then we're going to say ….

Neil Calman – Institute for Family Health – President & Cofounder
No. I think you're making a different point, which is, are these reminders that take place to say you're coming up for your annual exam, because we don't do any of those. But we do the, you've just missed your annual, or you've just missed getting your blood test kind of stuff, because otherwise the volume is astronomical. Then everybody is getting multiple reminders. I don't think we should specify that they need to be in advance of target dates.

Deven McGraw – Center for Democracy & Technology – Director
I agree, and I think by having a broader denominator base, which is to say removing the age brackets, it actually makes it much more flexible and easier for providers to decide the kinds of reminders they want to send and to who because now it's not 20% of people at either end of the spectrum. It's 20% of everybody. If they end up focusing on either end of the spectrum, that's fine.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…drop to 10% then ….

Deven McGraw – Center for Democracy & Technology – Director
It should give them some ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…drop the ratio then.

Deven McGraw – Center for Democracy & Technology – Director
…because if we're asking them to do 20% already in 65+ only and now they can do 20% in everybody and ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's 25% of people over 65.

Deven McGraw – Center for Democracy & Technology – Director
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But not it's 25% of all, but those are the people. You're adding the people who are less likely to need a reminder.

Tony Trenkle – CMS – Director of OESS
Right, and if you look at the reg, the reason we put it in that way is because of the 90-day reporting period and who would be more likely to get reminders during that period.

Christine Bechtel – National Partnership for Women & Families – VP
In 90 days.

Tony Trenkle – CMS – Director of OESS
In 90 days, correct.

Christine Bechtel – National Partnership for Women & Families – VP
But in stage two, it's one year.

Tony Trenkle – CMS – Director of OESS

If it's defined as a year in stage two, that would change things, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I wonder if this is one of those that could be embedded. In other words, it's very important that the EHR have this functionality, which is really accomplished in stage one, and we should maintain that. But this is on the road to kind of a functionality, so if you want to improve your quality, in preventive health services for example or followup, you're going to use a tool like this as one of your tools. Rather than—we have this problem of how to measure it, and we've come up with approximations and then all of the unintended side effects of measuring it this way. But isn't it going to be captured by the quality measures?

Christine Bechtel – National Partnership for Women & Families – VP
I understand what you're saying, and I don't disagree, but I think it's not a complete view, and the view that I'm taking and part of why I think we feel passionately about it is because this is a very patient centered measure. It is a measure of the health system proactively reaching out to the patient and engaging. So when I think about family caregivers, people with multiple chronic conditions that they're managing, the idea of making their lives easier through reminders about prevention and followup care is an enormous contribution. It's funny because when you went in the beginning, Paul, over our sort of principles, the one thing that was missing to me was tangible benefit to consumers. This is one of the few ways where they will really directly observe a change in the way the health system interacts with them. I think it's important for different reasons than quality measures.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's sort of the flipside of our problem list.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We want them to be veterinarians, right, because we get our cards ….

David Lansky – Pacific Business Group on Health – President & CEO
I agree with Christine's basic argument, but I think there are two caveats I don't really know what to do with. One is George's that there is patients may or may not feel like that's an added value for them, and we get that more from the patient experience side of the measures than we do from the process measures here. The other is sort of the perverse side of what Neil was saying is the better a practice is doing at keeping everybody current, the fewer followup reminders they're ever going to send. So setting a numeric threshold, you need to have 20% of your patients have to be contacted. I'm doing a really good job keeping all my mammograms, etc. above 90%, I'm never going to hit 20%. So I don't know how to quantify the threshold.

Neil Calman – Institute for Family Health – President & Cofounder
The only way you do that good a job is by doing ….

David Lansky – Pacific Business Group on Health – President & CEO
But you were saying, Neil, you would only send the outreach post failed followup, not as a reminder pre-followup.

Neil Calman – Institute for Family Health – President & Cofounder
No, I'm saying we shouldn't specify one of the other. I think whatever types of reminders, but I totally agree. This is one of the most visible ways in which this money, the money that we're putting into this will be visible to patients is calling out the fact that we're sort of asking providers to be proactive with them. I think it's a really important piece. So from my perspective, I think, keeping a percentage of 20% or 25% for a whole population is fine. I don't think anybody is going to really have a problem meeting that measure if they have systems in place to do outreach.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, the customers or the vendors are certified against patient preference, so that's in there, so that'll be there. You can roll that out. The content you're given, if you can give them some specifics, reminder

of visits and those kinds of things to give them some guidance, I think that will just take some of the uncertainty out of what you mean. Again, what's the intent, and just clarify that a little bit more.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
George, is it 20% in stage three or stage two? I think one possibility is stage two is to make it core, and then for stage three, you expand it to the entire population.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We already had 20% of the threshold in stage one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, but for only a selected population.

Christine Bechtel – National Partnership for Women & Families – VP
Which is by far the population that's probably going to end up with getting them the most. I just don't think it's that much of a stretch for stage two to keep the threshold at 20%, but broad and the base because, by 2015, if we're really only doing reminders to 20% of our ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, but we're thinking 20% because we think that might be the right ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…not ….

Christine Bechtel – National Partnership for Women & Families – VP
For prevention and followup? Prevention maybe, yes, but followup?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No ….

David Lansky – Pacific Business Group on Health – President & CEO
Reminding you go to an office visit is different than decision support to improve the quality of care.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's the problem I would argue. Just to come back for that appointment and have those routine blood pressure checks or however you get it done?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's a different kind of thing.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I understand it's a different kind of thing, but you're managing health.

Deven McGraw – Center for Democracy & Technology – Director
Let me ask Neil. When you say you don't think people are going to have trouble meeting 20% or 25%, do you mean that for stage two or stage three?

Neil Calman – Institute for Family Health – President & Cofounder
I was thinking of that for stage two because I think the number. We're going to get a little experienced with this stuff to know exactly what's going on. But I think there would be no problem for stage two, and I don't know what the number should be for stage three. I think we'll need to hear what some of people's experiences are with different types of populations. We serve a very low-income population where we're probably doing 80% now of people at one point or another during the year getting some form of reminder.

For our population, it's quite different. But I don't know what would make sense in terms of a number for everybody. But I think we should include both types because what we really want people to do is have

systems in place. Think about the process to generate lists of people who need certain things, and those lists become actionable, so those lists either generate letters, or they generate a list of phone calls to people, or they generate text messages. So we're basically getting people to evolve these systems.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think actually if we just say explicitly what we want, then we'll all agree. It's a matter of how to turn it into a metric. But I would want 90% or some high percent of patients who missed preventive care or followup to receive a reminder, who at least permit us to send them a reminder. I'd want the ability of patients to sign up for a reminding service that you have an upcoming appointment. I would make it optional. You could make it mandatory. That's kind of where I'd want to be. The question is, when you take that over the whole population, what number do you end up with? I don't know because there are some people who won't see a doctor for some years.

Deven McGraw – Center for Democracy & Technology – Director
That's the problem right there is what happens.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't know.

Deven McGraw – Center for Democracy & Technology – Director
No, because what happens then, and trust me, I just went through this. When I don't go to the doctor for two years, they hijack my prescriptions. They won't refill them until I physically go. I want to be able—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For good reason.

Deven McGraw – Center for Democracy & Technology – Director
Right, but ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
You're agreeing. Yes.

Deven McGraw – Center for Democracy & Technology – Director
Maybe, but maybe not, right? All I'm saying is, it shouldn't be hard to deliver ….

Neil Calman – Institute for Family Health – President & Cofounder
…doctor?

Deven McGraw – Center for Democracy & Technology – Director
What?

Neil Calman – Institute for Family Health – President & Cofounder
Are you still going to the wrong doctor?

Deven McGraw – Center for Democracy & Technology – Director
Yes, I am. Thank you, Neil, for that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Mine get hijacked too.

Deven McGraw – Center for Democracy & Technology – Director
But nonetheless, I think we're not making the final decision here. I think we ought to ask for comment on 20% and see what the experience is in practices. We've got one clinician who does this on a regular basis who is saying this is no issue. Let's figure out what everybody else says because I think, George, part of the issue is I want reminders in a slightly different way for different purposes than what I hear you saying.

David Lansky – Pacific Business Group on Health – President & CEO
Two things still on my mind: I think the issue of active patients will become controversial, as we try to roll this out to the wider community, the less organized care world. The small and idiosyncratic practices who may be EPs, but don't have established relationships with a lot of patients that are hard to know who their active patients are.

The second is, I do think that both the two quality measure domains with the quality measures around prevention and the quality measures around patient experience are better outcomes to get at this than prescribing a process. There may be practices for whatever reason … their communities or whatever have ways of achieving high performance that don't include a lot of reminders. I don't know that, but I wouldn't overprescribe this methodology to achieve good results.

Deven McGraw – Center for Democracy & Technology – Director
Right, and I think we can assess in stage three too whether we still need it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next one is something that we had put in, we had recommended, but wasn't in the final rule, and that's the progress note. How do we feel about it at this point?

Neil Calman – Institute for Family Health – President & Cofounder
I made a big play for this in stage one, so I guess unless we want to replay the ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We'll save you the trouble. We'll replay it in our mind. Are we still in favor of doing that, let's say, by stage three?

Deven McGraw – Center for Democracy & Technology – Director
What's the goal we're trying to achieve …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, we would like the whole record to be in one place, in the EHR, and not have a separate paper system. A lot of information is just captured nowhere else in a structured way, and so it ends up in the progress ….

Neil Calman – Institute for Family Health – President & Cofounder
And you can't share it with patients if it's not electronic, so if our goal is to get people to be able to achieve complete access to their medical record, at some point that entire medical record has got to be electronic in order to achieve that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Or share it with other providers.

Neil Calman – Institute for Family Health – President & Cofounder
Right.

Deven McGraw – Center for Democracy & Technology – Director
Sorry, Neil. Go ahead.

Neil Calman – Institute for Family Health – President & Cofounder
For me, that would be my number one most critical reason to do it. We want to start signaling that people should be sharing more openly things like progress notes, histories, things like that for patients to participate in that. Then we're talking about people being able to communicate electronically with their providers. So those things get captured in the EHR. If you have an electronic dialog with the provider, it's got to get captured in the EHR. What you end up having is duplicate sort of paper stuff and electronic stuff, and I think that's a real quality issue that you don't have one place to look for all of the recorded

notes on a patient. At some point, it's got to be essential. I don't know. At some point this has to be included. Otherwise we're never going to achieve the long-term goals that we set out.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Maybe a temporizing step here for stage two might be to make this one of the menu items that we could say that progress notes would be something we could have as a menu in stage two.

Neil Calman – Institute for Family Health – President & Cofounder
Only if we call that out as a requirement in stage three because ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, I think that's where we'd be headed, Neil.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We're all for progress notes. I was one of these strongest proponents. We suggested it twice. We didn't put it in for some particular reason. Some of them are probably suggested in the final rule. There may have been other ones. So, I think, knowing why it's not in there would help us create a measure that would be acceptable. There's no sense in suggesting the same measure for—obviously this measure was important on day one, so suggesting it a third time, even though it's stage two, may not ….

Tony Trenkle – CMS – Director of OESS
Going back to the regulation to get the official explanation of why we didn't put it in there, but I do know that one issue was defining what was a progress note and what was in that was one of the issues.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. I think the feedback on this one too has been the specificity, the types of notes, and do you really need them all, or are there some minimums that you want to specify also? Today, you're going to have to capture some progress notes anyway to be able to do some of the measurements. So it's kind of a byproduct of having to do measurements, so you're going to have to move forward on structuring and capturing the data. So you're getting some of it as a byproduct. But again, the feedback in terms of even like capture all clinical documentation is the same thing with some specificity in there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Does anybody want …?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
What's high priority? What is it you need?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do either of the strong proponents want to offer a draft definition of progress notes? Whose notes?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
To make it easy to measure, you do one electronic note per visit. So if you're outpatient, you would presumably generate a note of some sort. If you're inpatient, you've got to have many notes. But if you just ask for one, the admit note would be easy. So that would be a way to just insure that there's electronic note entry. Now how that gets in there, does it have to be—we didn't want to force it to be structured.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, we didn't want to force it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Which means dictation, I guess, is okay, as long as it meets all the needs, so I think we would do that. That's what it would look like. Then the question is, we had a fear that you could actually, at least what we propose in stage one, could be implemented while staying on paper in your progress notes, and CMS

argued that that was unlikely to happen. We don't have any experience yet. So do we need the rule or not?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The reason not to say physician progress notes, and the reason is there's only one way you can bill, which is to have documentation from the physician, so wouldn't that be fairly safe from a minimal kind of point of view?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And to say, it seems like we send two messages though when you say it can be dictated. You need elements of it to be able to do your measures. It's like … and you have to have that for stage one, the elements.

Neil Calman – Institute for Family Health – President & Cofounder
…can go into an electronic health record.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
We do that all the time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And they're very valuable.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. Dictation and electronic health records are not mutually exclusive. A lot of people dictate notes that are then put into the electronic health record by the people who transcribe them. They can be put in directly and then verified or sent back in messages and then verified and accepted into the electronic health record. There are a variety of different workflows for that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How do people feel about, let's talk about stage three first, physician progress notes are captured in the EHR, and that's agnostic about how it gets in there versus directly entered or transcribed.

David Lansky – Pacific Business Group on Health – President & CEO
Physician as opposed to?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The person who is doing the billing, let me put it that way. Is that the requirement for billing? If it's a nurse practitioner, for example, that's fine. Whoever is the ….

David Lansky – Pacific Business Group on Health – President & CEO
Eligible PDP.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you, the EP progress notes.

Neil Calman – Institute for Family Health – President & Cofounder
Can I just ask a question? Let's just think about what we're conceptualizing here. People who come into a system with an electronic environment should have no paper record. There's no reason that there should be, that we should be, and here's an efficiency measure. There's no reason that we should be doing anything that would encourage people to be maintaining duplicate systems where some stuff is on paper and some stuff is electronic.

I think, for stage three, it's perfectly reasonable to say that all notes related to a patient's care should be captured electronically because that's ultimately then you have a very expensive system where people are running electronic and paper systems, medical records rooms, and server rooms side-by-side. That doesn't really make any sense ultimately from an efficiency point of view. I think, by stage three, we should be able to say that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
An electronic version of those notes are captured because sometimes you'll scan one in and save it that way and that type of thing.

Neil Calman – Institute for Family Health – President & Cofounder
…but the electronic system becomes the repository for all notes related to the patient's care.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm not sure how that translates. One, I think we heard, George, is instead of just one note, any note, it's the EP's progress note to be specific.

Neil Calman – Institute for Family Health – President & Cofounder
That means nursing notes could be somewhere else, which again, you're creating a system where notes are in different places and things, and then the providers can't see the notes that the nurses wrote. I don't think that makes any sense in terms of an organized, high quality system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But on the other hand, just because we don't say it doesn't mean they will try to perversely create a less efficient mechanism. People are going to put create a mechanism that works best for them, both on the quality side and efficiency side. What we're trying to do is be specific, vis-à-vis Charlene's recommendation. We want to capture the documentation of the EP, and one of the reasons you would do that is one is clinical care, and the other is the billing. It just makes perfect sense. It is not to say, and what we did is we got around the lack of specificity, the ambiguity, which is why CMS didn't include it in the first place of, well, which notes and how much. We tried to get the best of both worlds. Is that acceptable to you, Neil?

Neil Calman – Institute for Family Health – President & Cofounder
Yes, I understand that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do we want to say something about stage two then?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
…aren't certified against this yet today because it wasn't there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's true.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Not that it's not in many systems.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Many systems have this piece.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We might try some low threshold just because they can do pilots because it truly is a different workflow and a big training issue, etc. But we want to get it certified and get them, and then show the path.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I just wonder if we should again allow this to be something on a menu in the stage two. There are some things to be worked out here. In the final rule, they talk about transcription, voice recognition software, direct entry. Charlene brings up the idea of a written text that's scanned afterwards. There may be some things that need to be explored in workflow and in design of the EHR that we should allow us to get some progress in this area.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is there any reason that, Tony, we shouldn't—it would be inadvisable for us to use the menu approach in stage two?

Tony Trenkle – CMS – Director of OESS
That's certainly something we haven't said we were going to follow in stage two, but it's certainly we've implied will continue to use the core menu approach, but we haven't put it into regulation yet, and that may be one of your things to take a look at also is the core menu interaction … as a committee in terms of recommendations.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'll just put in a comment, question mark menu item, and not define that now. I will point out though, if we're worried about turning this on because it's going to be so hard, no one is going to be able to do it, from two different points of view, then it's not clear that the argument that this is so implicit in the use of it that we don't even need to make it a core measure contradict each other. If it's harder, it's easy, but it's not both. A lot of things are both.

Art Davidson – Public Health Informatics at Denver Public Health – Director
But you submitted it twice, and I got shot down.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
For a number of reasons, that's why I wanted to know what the reasons are to see if we could adjust the measure to make it easier. If it's 90% of it is have at least one electronic EP note, that's probably easier to measure than the thing we first sent off. Plus it's been two years of time for the industry to catch up, so if some of the implicit concern was can people really do this, this gives two more years for them to get there. If we make it 30%, I don't know if that helps that much, but it gives them two more years to get there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. I'm going to try to wrap this next one, the clinical documentation, which is the inpatient side, into the one we just did. Is that fair for me to do that?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Yes. The only feedback we had on this one, again, clinical documentation, at least on the hospital side, includes a lot of the nursing staff. Now that can be just a given, but the feedback we got is just the nursing notes on the inpatient side are important.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are what?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Are important.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Nobody is denying that they're important. The question is, is it helpful to say two groups like EP and nurses, or to just leave it as EP, knowing that it's not as if we're preventing things from happening.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We can't say EP for hospitals though.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…the definition of the billing provider.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Clearly they said, if you want the physician, you've got to do the physician notes, and then the nursing piece, but try not—take the ~~-all~~" out basically.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. A lot of the problems we ran into was the ~~-all~~", and that's why I'm trying to be specific. If we make this one definition applied to both EP and hospitals, does that help?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Or we could just go after something that we can define like the admit note is something. I guess progress note is just … note.

Deven McGraw – Center for Democracy & Technology – Director
Don't you mean discharge note?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Discharge summary we have already, so we could put it in or not, but ….

Deven McGraw – Center for Democracy & Technology – Director
No, that's … for the patient, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Discharge instructions are for the patient, but discharge summaries are ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I mean, the issue, you've got the summary. It's dictated. It's days later. How is it going to fit in? That's a real messy spot. I thought we were going to actually raise the bar to automate some of the physician documentation piece. At least it should be … in stage two to move the bar, and we have to do it anyway because we're going to have to capture the measures from it. There's also very relevant data in the nursing documentation to be able to conform the measures.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're arguing to expand the notes?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I really struggle between not putting this on here and having to do it anyway because we have to do it to capture the measures. That's where I really struggle because it's part to capture some of those measures is part of the documentation process today.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm still asking the question. Are you arguing to expand this definition?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
To include nursing on the hospital side.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Nursing is hard to define. There are flow sheets, spreadsheets, actual notes, so we'd have to think about how we're going to measure it. Often if it's a good application, it doesn't look very note-like because it's incorporated into a workflow. I certainly want the whole thing to be automated.

Neil Calman – Institute for Family Health – President & Cofounder
And that is really important to sort of signal that that's the direction that we're really moving into an integrated record that has ways of capturing that stuff as meaningful information that providers or nurses can use.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The metric is, we want to eliminate the paper note.

Neil Calman – Institute for Family Health – President & Cofounder
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If we could measure the opposite and presume that it went onto electronic ….

Neil Calman – Institute for Family Health – President & Cofounder
There's also a real issue in rounding in hospitals where information is in multiple locations that I believe is a safety issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Part of our Achilles heel on the previous recommendation was the use of the term ~~a~~all".

Neil Calman – Institute for Family Health – President & Cofounder
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One of the things we're trying to do is to precisely define whose note we're talking about and hopefully that can apply to all patients. They apply to all patients, and the outpatient setting is certainly the EP, and the inpatient would certainly be both the billing provider and the nurses. We can say it that way. Do people want to do that?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Nurses is vital signs, I's and O's, clinical observations, and med administration?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
There are a lot of data elements that are going to feed into. There are a lot of pieces that are standard. You want to get those data elements standardized so that they can feed these other processes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's probably the argument.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
They'll be a subset, right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm using George's argument to say it's a lot harder once you say nurses entry than to describe the provider's progress notes, so the required physician notes. And I'm just trying to get us to the things that are easy to define because that was the killer when we tried it before. That's my rationale.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
The positive is that there's all this work on continuity of care documents, 400 elements in it, and we've got 8 now. So if we even work backward, we'll start to define some of this stuff. I think there needs to be an indication of at least capturing that data necessary to be able to inform these other processes in the clinical documentation from the nurses and the physicians. At a minimum, we have to do that. I mean, that's a given, but we don't certify to that. We just have to make sure we show that at the backend.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Maybe we need what?

Deven McGraw – Center for Democracy & Technology – Director
I do think we have to ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was trying to get through a stretch in ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I know. I know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But it's not going to happen.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I don't think you can get the specifics of vital signs and that type of thing. I think we're going to have to ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But, Charlene, that's why I think we're trying to avoid getting into that definitional problem by limiting it to what people recognize are physician progress notes that are required.

Deven McGraw – Center for Democracy & Technology – Director
Do we lay out the goals we're trying to achieve and ask people specific …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We can. Can we start with the physicians, who we all agree with, and then ask in the RFI, as Christine suggested, what do we do?

Christine Bechtel – National Partnership for Women & Families – VP
That'd be great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Despite only having two left, I hear the pains of hunger.

Deven McGraw – Center for Democracy & Technology – Director
Yes. They could be two that take an hour.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Hopefully not.

Christine Bechtel – National Partnership for Women & Families – VP
Are we going to do the eligibility ones?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Originally we were scheduled for an hour. Does anybody know where there's food accessible easily here? That's the whole….

Deven McGraw – Center for Democracy & Technology – Director
I think right out on Elm Street there's a lot.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But it'll still take the minimum of 45, it seems to me. Is 45 a reasonable time, so we'd talk about 1:15? Great. Thank you.

Deven McGraw – Center for Democracy & Technology – Director
Paul, do you want me to look up …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't think that's what we're ….

Deven McGraw – Center for Democracy & Technology – Director
There's a ton of notes that were taken.

Neil Calman – Institute for Family Health – President & Cofounder
I'm going to be jumping over to the airport and picking this up on my cell phone until my plane leaves, so I'll try to catch up with you guys.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks a lot, Neil.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Thanks, Neil.

Neil Calman – Institute for Family Health – President & Cofounder
Sorry about being remote, but I've got no choice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, it was working pretty well.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
And I thought that was there. I though that medical, what happened to medical history? It was on that list. We were going to do that.

Deven McGraw – Center for Democracy & Technology – Director
Yes, because ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Wasn't it on there?

Deven McGraw – Center for Democracy & Technology – Director
I didn't see it on there.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I thought it was there.

Deven McGraw – Center for Democracy & Technology – Director
Because that's not part of the CCD we capture there.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I thought patient family medical history was there, right?

Deven McGraw – Center for Democracy & Technology – Director
We've not gotten there yet.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
No, we haven't got there yet. I think they're going to lose ….

Deven McGraw – Center for Democracy & Technology – Director
…medical history, social history ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
And then the specialist report to the external registry we want out of here.

Deven McGraw – Center for Democracy & Technology – Director
Here's the other part of the CCD: family history.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Give me the name.

Deven McGraw – Center for Democracy & Technology – Director
Family history, med history.

(Break for Lunch)

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, everybody. We're back from lunch, and we're ready to resume the meeting. Just a reminder though for members of the workgroup to please remember to identify yourselves. We've had a couple people wondering who is speaking, so if you could do that, that would be terrific, and I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Welcome back, everyone. Thanks for a productive morning. I think we've made a lot of progress. We knew and scheduled ahead of time that this first category is a huge one, and that it would take much of our time for today.

Where we left off were just a few remaining on the list for category one. Just to caution, and I think we've done a really good job so far. Our process was, we were going to go through some of these, what's already on the table, and what in our mind do they look like in stage three, and then work backwards to stage two.

We want to be careful not to end up with a whole lot more than the kinds of things we're asking people to focus on in stage one because you can see how this can really blossom in stage three. So the process that David had suggested upfront is we'll make sure once we go through and make sure we've covered the bases, that we go through and also look for ways of clustering, clumping, or pruning so that we don't overburden the whole community in terms of requirements because we're not trying to get in their way, of course.

The additional filter we're going to go is go back and check against the heading, which was the quality, safety, efficiency, and reducing disparities. We'll also look back with a different set of perspectives. Have we accomplished? Have we pushed things in the direction that we were headed, which is improving the health outcomes of individuals and populations. Those are the filters we still have to apply.

Where we left off was the record family history. Now that was something in our original draft, was not in the meaningful use and final rule. We want to make sure that, as we did with progress notes, we did add that on because of the strong feelings of members of the workgroup. But we want to respect that CMS and ONC had their reasons for not having it. So either we think there's a new thing to add in later years, but let's not just continue to keep adding just for the purposes of adding.

Record family history, is that something that can be? I'm going to put the test, and that did not survive in the final rule. Is that something that can come about as a part of getting, reporting under quality measures and improving, or is it something we think has to be there structurally?

David Lansky – Pacific Business Group on Health – President & CEO

I would think it's a structural question. I don't know. Maybe Charlene ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I think it's structural.

David Lansky – Pacific Business Group on Health – President & CEO
Does the certification address this at all at this point?

Josh Seidman – ONC
I just want to clarify, a lot of those things are things that weren't recommended for stage one. They were in the stage two.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Original stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good clarification.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
And these could potentially be many things … category.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
But it's the social history, the medication history, so there are elements that are included, but those pieces aren't explicitly identified.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Is it a high enough priority at this point that it has to be an objective, though, is my question, family history, because there's a lot of the record we could go through that is not in there, and so this is the one next. Is this really going to impact the kind of quality measures we're likely to do in the next two years? Maybe, maybe no. I think cardiac, preventive care, whatever.

Perhaps the other question I had was structured. I'm not sure we know how to do structured family histories all that well. It's a lot harder than it looks because we've tried to do it, and we have free text because there are too many complications in the thing. Then what system would really be able to use that structured information, which is so nested: my brother's uncle, my half brothers? It's just hard for people to get that in there. I think family history as free text would be important, but I'm not sure it rises to the level of an objective.

Deven McGraw – Center for Democracy & Technology – Director
I think my other concern is that family history data be collected where it's clinically relevant to do so, and only in those circumstances because I sometimes worry with all these data collection requirements that we're not collecting data for the sake of collecting data, because that's always not a good thing from a privacy standpoint. If there's a reason for a clinician to collect family history, there ought to be a space in the record for that to go, but not a requirement to collect it at every visit or even to collect it for every patient.

Christine Bechtel – National Partnership for Women & Families – VP
What are the purposes that we would use it for?

David Lansky – Pacific Business Group on Health – President & CEO
I think the issue partly back to the certification question. If people are forever able to say, well, I'm on an EHR, and there's no place to store this data, so I'm not going to capture it because I have no place to capture it to store it. For health risk assessments, for various sort of genetic and family predictive uses,

risk factors, risk adjustment that's done to do risk factor, risk adjustment for things like predicting outcomes, we wouldn't be able to ever capture it once we give it up in this process.

Deven McGraw – Center for Democracy & Technology – Director
Right.

David Lansky – Pacific Business Group on Health – President & CEO
On the other hand, I totally agree. We don't want to require it, except in the context where it makes sense. So I don't know if there's a way we can think about standards ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think, in the absence of a structured environment to store these data, I would think that this would be something valuable for clinical decision support for preventive measures. But since we don't have a good method to collect and store these data, it's really pushing beyond what we can legitimately ask providers or EHR vendors to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think most vendors have family history, and most of them are captured in coded form that's defined locally because of the lack of problems and the issues that George raised. I don't think it's that we have to require people to put it in. It's just that it's not in a useful way mainly because of the infrastructure and the lack of standards, etc. I think the most recent comments or all the comments so far have been more like it'd be an implicit requirement.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Implicit under documentation?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. By implicit, it's in the quality measures. You're going to – eventually we're probably going to end up seeing quality measures that assess people's risk for certain things such as heart disease, and people will collect that as a byproduct. Like I say, we already have functionality in the current records. But it is a signal to the industry that we need to find a better way of capturing it in a standardized form so that it can be useful. This might be an opportunity to prune. Not prune it because … it was on our draft matrix, but maybe it's not something that we're thinking as ready in stage two in 2013. Is that a fair assessment? The next one is patient specific care plans.

Josh Seidman – ONC
Let me clarify, that should have just been for EHs, for eligible hospitals. That was where it was put in by the policy committee last summer.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Right. The pushback I would have again on this space is, again, I think getting some work done, linking it to measures and standardizing it is important because, as you look at the future in terms of accountable care, the more you can have that right information at the point of care when that patient comes into the system, the best you can put them where they need to be. Even best practice in ED is like if you've got this information about the patient, and you can direct them accordingly, and they can get to the right place. There's some elements of this you would really want to know and capture that, I think, is the early part of the triage process. What those are, I think we need to think about. It could be linked to measures, but it's, I think, an important part of the process that we don't want to just overlook, so I tend to think we might need to be more explicit or encompass under documentation, one of the two.

Christine Bechtel – National Partnership for Women & Families – VP
I think I'm looking at it from a slightly different perspective, although I don't disagree with that, which is that one of the biggest takeaways that I heard from the care coordination hearing—

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
—was this need for a shared care plan—

Deven McGraw – Center for Democracy & Technology – Director
Ditto.

Christine Bechtel – National Partnership for Women & Families – VP
—that is transmitted and coordinated across providers, which would then require you to actually identify the other providers that need it as well. I think this is actually one of the most important elements that we should discuss. Whether it goes here or under care coordination, I personally don't care. But I would really like to see us have a shared care coordination plan with patient input, patient goals, etc. Certainly signaled for stage three if we think it is not something that is in a place that is standardized enough. But I think the closer we can get to it and the pathways in stage two, the better.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that is listed under care coordination.

Christine Bechtel – National Partnership for Women & Families – VP
It is?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
I was actually kind of jumping back. I jumped back up a row, which ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
…family history, but that links to the care plan anyway. You have to have family history to develop the care plan to some extent, so those two actually go together. Yes, I'm supportive of getting care planning in there.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Deven McGraw – Center for Democracy & Technology – Director
I suggest we raise it in the care coordination bucket.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I would suggest that too.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So is that inside the summary of care record?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, it's a separate. It really came from our care coordination panel where you would love to know who all is involved in my care and what's the shared game plan. Everyone would love to know that. That came in loud and clear.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We talked a little bit about the external, then we did have, as a placeholder for stage two, conduct closed loop medication management in the hospital setting.

Christine Bechtel – National Partnership for Women & Families – VP
Can you remind us nonclinical folks what closed loop med management is?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Closed loop, you enter your medications with the appropriate physician support. It gets transmitted to the pharmacy. You properly identify the individual. Oftentimes it's done through barcode, which shows that you got the right person. Then you administer it, so you can see the entire loop of order through consumption on the patient … and you try to prevent all the potential errors that can occur in that process.

Deven McGraw – Center for Democracy & Technology – Director
Would that be taken care of better by an outcome measure?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a question.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
This is pretty standard. People kind of know what this is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's becoming a standard.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Yes. People know what this process is. They know the steps in the process. They've been automating toward this for a long time. This is a pretty straightforward one to put on the list, and people know what to do. They might argue what pieces of it.

Deven McGraw – Center for Democracy & Technology – Director
Right, but that to me argues not to mandate it as a separate process and measure it that way, but instead on the assumption that people do this or know that they should be doing this, and are acting toward that already to assume that that will get—that's how it will get done for outcome measurements.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
But the challenge I think they'll find in the measurement, and I think you'll find this when you drill down to the error space, there's a lot of debate about which errors to capture. I mean, I think you'll sort it out. I think it's just they'll stay as a signal on here for the purposes of right now until we get through some of that measurement process.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Deven, can you describe a little bit about what kind of outcome you're thinking about in this …?

Deven McGraw – Center for Democracy & Technology – Director
Yes. In other words, the purpose of a closed loop process, if I understood it, and just based on the description I got today, so I would not consider myself an expert, but the purpose is to make sure that the medication gets administered to prevent that step from being left out. This one feels to me like there's a lot in these measures that's about handholding. I want to try to get away from that where we can, like you should do this and then this and then this and then this. Whereas what we really want is for care to be improved, and so I guess I'm just sort of picking, teasing out about whether this one is one that's a little too, thou shalt do this, this, this, and this, when we don't really need to do that. But I'm happy to be proven wrong. But it sort of looks really top down management where we might not need it.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Something along the line of identifying a type of error that should be reduced to a certain level.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Is that what you're thinking?

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Okay. I thought I heard earlier that the errors are difficult to identify and to measure.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Right. The people working in this space or identify these errors have found it challenging to really—you can identify what the percentage of your patients who receive the wrong drug, those types of things. But to get to what's the measures that matter have been a challenge in terms of the patient safety folks. Getting to that end game in terms of what gets measured consistently, I think, will be part of the challenge because there are a lot of things that are measured out there right now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Since, Deven, we can't actually estimate the errors made without instrumenting the process, I mean, that's the argument. It doesn't mean that there can't be. Actually, as a result of this structure or requirement and the functionality provided in the EHR, and the way it's used for closed loop meds management, then you can actually quantify the errors that are made of different kinds in this whole process.

Christine Bechtel – National Partnership for Women & Families – VP
That may be the outcome measure then is percent of errors detected or something that we go back ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Or prevented. There's good work in this space, so ….

David Lansky – Pacific Business Group on Health – President & CEO
Another ….

Deven McGraw – Center for Democracy & Technology – Director
David?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That'd be David.

Deven McGraw – Center for Democracy & Technology – Director
I guess I'm not opposed to leaving … for now since there's some unanswered questions, but I'd like to have it as a potential pruned end of it ….

David Lansky – Pacific Business Group on Health – President & CEO
It sounds like … comment, let's see if we replace it with an outcome measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good.

David Lansky – Pacific Business Group on Health – President & CEO
Or effectiveness measure might be a better word for this.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Are we saying that maybe stage two could still be some measurement like this, but stage three should be more directed at an outcome, or are we saying that right now we should be looking at a specific outcome.

Christine Bechtel – National Partnership for Women & Families – VP
I think we're saying, or at least I know I'm saying right now the quality measures workgroup should look at it. Is there an appropriate outcome now? If it's more appropriate for stage three, then so be it, but I think we have to know.

David Lansky – Pacific Business Group on Health – President & CEO
This will actually lend itself to our process on the quality measurement side is to go out to the larger measurement community and say what do you got, so that we can go to some of the people Charlene is referring to and say what measures are in place that we could adapt, and maybe we'll get a good answer.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that completes what we had in terms of looking at where we are with the final rule, what we've set as placeholders, and sort of targeting both the combination of structural endpoints, as well as outcomes in some cases. Let's go back to the filter. One of the checks that David had, which is have we done enough in the quality, safety, efficiency in reducing healthcare disparities column? Make sure we get that. But clearly like CPOE would be quality, safety, and efficiency.

Deven McGraw – Center for Democracy & Technology – Director
No, I actually am not sure that it's possible to do that check now without seeing it merged with the measurement stuff. It's in so much of what we took off the table or potentially took off the table was based on when we think we can take care of this in the maintenance standpoint. I guess we could go through as a sort of do we see any obvious holes. But it's just; it feels premature.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Is that … David?

David Lansky – Pacific Business Group on Health – President & CEO
I was looking forward to the exercise until Deven spoke up.

Deven McGraw – Center for Democracy & Technology – Director
I'm sorry.

Christine Bechtel – National Partnership for Women & Families – VP
But I do agree ….

Deven McGraw – Center for Democracy & Technology – Director
Let's do it.

Christine Bechtel – National Partnership for Women & Families – VP
There probably are some holes on efficiency where ….

David Lansky – Pacific Business Group on Health – President & CEO
Yes, no surprise, I think we know where the holes are.

Christine Bechtel – National Partnership for Women & Families – VP
Right, and probably on disparities, although we have the data collection piece, but again to Deven's point, if our recommendation is to report to quality measures … disparate variables, then that takes care of it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
My recollection, and I guess I could look it up in our blue matrix, so we had, I think, about three clinical efficiencies measures. One was in generic prescribing when available. Another was simple, looking at the indications for advanced imaging, not even saying anything, just looking at it, recording indications for advanced imaging. Then we did have a couple, one might call, administrative efficiency measures. And I

think, rightfully so, CMS took them off the table. I think were a bit stretching in trying to get them in the efficiency bracket. I think it would be more productive for us to look at clinical efficiencies based on ….

What do people think about that? I think CMS signaled that they certainly had the right to put the administrative efficiencies back in. If they were going to put some things, I'd almost suggested that maybe we might prefer the clinical efficiencies more than administrative, at least from our vantage point from an EHR point of view. Do people have any thoughts in that area?

David Lansky – Pacific Business Group on Health – President & CEO
One thing we talked about when we relaxed the efficiency objective was that the clinical decision support rules would be a place that would get absorbed. But we might characterize what future clinical decision support rules we encourage to favor those, which support greater efficiency and use of resources. So we might want to come back to our kind of placeholder we had for the CDS guidance. We stuck in that one phrase about public health, but there may be an opportunity to really think through much more carefully if we're going to say you should have five implemented clinical decision support rules, what characterizes those five? Right now we've sort of inched our way toward that by talking about local and national and talking about public health and other, and we had the one about imaging ordering as a sort of potential one. I feel like that row 19 there has a lot of potential for future refinement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point. We can add those as other considerations. I think we should add to your growing list of the quality measures because ….

David Lansky – Pacific Business Group on Health – President & CEO
Efficiency measures.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, and you can refer back to our original draft.

David Lansky – Pacific Business Group on Health – President & CEO
That made me wonder for our discussion here whether anybody has a bias about where the functional requirements down this list here, which we need to encourage in order to facilitate better efficiency, measurement, and performance over time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it's really information at the point of ordering, so really it's CPOE, so you would need to consider what is best for this individual patient, and what we meant by patient specific care plans actually is, yes, there's something on stroke patients. But this patient is a stroke patient with diabetes, etc. So right now these order sets and care plans are very generic. They basically are sold as a set, and they don't necessarily have the mechanism … to an individual. That's one direction.

David Lansky – Pacific Business Group on Health – President & CEO
I'll give you an out-of-the-box one that I know we won't want to pursue, but I'll put it on the table. At the time of ordering, do you know? The patient or the physician know the relative cost of the available options for a lab, which lab I send this to, which pharmacy I send it to? Whether or not I order a particular device, or even the physicians whom I refer, if it's a high utilizing specialist versus a conservative specialist. None of that, which would be very efficiency enhancing, none of that information is available. It's basically the formulary translated to all non-Rx services.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, and your question was, how do we do that in the functionality. I think you do that as the CPOE side. It's just a matter of what you draw on, and you've got to have those databases of the kinds of data you just enumerated available, and most of that, of course, is not available. Actually, I don't know, 20, 30

years ago, Regenstrief did a randomized control trial on just the lab cost and was able to reduce that by 15%. That's less than 20 years ago, and so that kind of information is available. If we had the information about costs for any of those number of things, I think you can bring that ….

David Lansky – Pacific Business Group on Health – President & CEO
But is there a pathway? Back to the certification arm, to begin to encourage the vendors to have that capability linked into the CPOE, even if it's an empty table today.

Christine Bechtel – National Partnership for Women & Families – VP
Or could we ask the standards committee to work on it because I'd like to see cost information for both providers and for patients.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Again, the issue here is that it's not that the vendors can't import that data. It doesn't exist out there.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I think it's not my health plan, and again, I can barely figure out what's covered in my health plan, let alone all those calculations that they do. Those tradeoffs depend on the negotiated rate and all those types of things, so it's a challenge.

David Lansky – Pacific Business Group on Health – President & CEO
I think our job and part of the policy committee is to send a signal to the industry of where it needs to go to support congress' objectives, which are pretty clear in terms of affordability, like the name of the Act.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I don't think clarification helps is all I'm saying.

David Lansky – Pacific Business Group on Health – President & CEO
Sorry?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Certification won't help you because ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

David Lansky – Pacific Business Group on Health – President & CEO
If the product has the capability today, if I came up to a vendor with a list of prices of laboratory services in the Bay area, and I wanted to populate my Allscripts, Epic, NexGen product with that data, could I do that? The CPOE would know what to do with it?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I wouldn't say CPOE would necessarily across the board know what to do with it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
One of the things that we could do would be to schedule a hearing on it this summer because we know it's not ready for stage two, no doubt about it. But how do we figure how to get the infrastructure in place for stage three and beyond, and after we get through this initial traunch of work around stage two, I think it would be appropriate to do some hearings. But while I have the floor, can I just slide that there were two things that were not included in the final, and I didn't see them in the chart, and we may or may not

want to consider them. One was percent of claims submitted electronically to all payers, and the other one was percent of patient encounters with insurance eligibility confirmed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Those were explicitly deleted by CMS, and the discussion we're trying to have is, okay, if you're going to add something, and we're trying to not add a whole lot, but would you choose those administrative efficiencies versus picking on some of these clinical efficiencies that we were just talking about.

Christine Bechtel – National Partnership for Women & Families – VP
I just want to suggest that we parking lot some of it because, I think, until we understand from the quality measures workgroup what are good measures of efficiency or maybe, David, we could say, here's a couple to remember. It's hard to have that conversation about tradeoffs when we don't have what we're trading off to.

David Lansky – Pacific Business Group on Health – President & CEO
This area is complicated because CMS took off the table the administrative functions.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

David Lansky – Pacific Business Group on Health – President & CEO
But they clearly made a place to bring them back. So if for stage two CMS intends to bring administrative simplification and the link to practice management systems back on the table, we would ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we're building a hearing list, which we have time to do, but that's a good one.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Are we saying that the electronic eligibility verification is something that we don't think it's ready for right now? Do we still need to a hearing on that? Wasn't that one of the efficiency measures we had?

Deven McGraw – Center for Democracy & Technology – Director
It was percent of patient encounters with insurance eligibility confirmed, although now that I'm thinking about it too, we have a lot of recommendations from the eligibility workgroup. I think the question is, which of those apply for meaningful use because if we're thinking about making sure that patients are connected to all the supports and services that they're eligible for, it seems to me that the point of care is one place to have that conversation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That brings up a good point. I think when we say parsimony, we shouldn't be just talking about from this particular workgroup of this particular FACA committee. The government has a whole lot of things, whether it's eligibility or the e-prescribing. In a sense, I think we would all be well served if we were efficient with all of the rules as well for everybody's benefit, whether it's the providers or the vendors or just the administrative burden of delivering services. It would be nice if we could try to keep a line. Where someone else is doing this work, let's not repeat it and add our new twist, which makes it essentially another reporting exercise.

Christine Bechtel – National Partnership for Women & Families – VP
Right, and I'm certainly not suggesting that. But I don't recall whether the eligibility group had specific recommendations for meaningful use, so I just want to flag that as something we might need to check on.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
…manuscript, I think that there's a lot of measures of this adherence to this today. I think that would be a great place to start in terms of informing what the current status of these capabilities are today. I know your focus is to clinical, but it's that broad … because there's good work out there in this space.

David Lansky – Pacific Business Group on Health – President & CEO
…rather than necessarily wait until summer, it would be helpful at least to the quality measures group and maybe to this group to have a hearing sooner on efficiency. I talked to a number of people, for example, in the health plan world who have whole libraries of measures we haven't really talked about or looked at.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I sort of heard that from Christine's comments, so that and Tony had asked us to explore advanced directives as another example we get additional …. It doesn't have to wait for summer. Have we exhausted the pleasure from this exercise yet?

David Lansky – Pacific Business Group on Health – President & CEO
Yes. I'm feeling satisfied.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then Christine and Deven's point of let's make sure we've covered the themes needed to improve health outcomes. Have we covered those combined with the measures that are yet to be done, which are entrusted to David and David to get done?

Christine Bechtel – National Partnership for Women & Families – VP
I just don't think we can answer that question until we see what the measurement piece looks like.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. In fact, when are you reporting on that?

Christine Bechtel – National Partnership for Women & Families – VP
That seems like so much more important from an outcome ….

David Lansky – Pacific Business Group on Health – President & CEO
Every month, but it won't be a real answer ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's not that far away, so we will get a chance in October and November to feed into that process, and you just said, that's where the end game is, so we've got to make sure that that's there. We have to make sure we've covered the enablers to get there, and I think we've been trying to …. Okay. Moving on to patient engagement, the first one up was, it has to do with the hearing, I believe.

I think it was Dave mentioned, Dave deBronkart mentioned, just give me the data, damn it. I mean, get access to the data no matter where it is, just like we would like to have access … as well. The end game then is if they can, in whatever instrument, PHRs as a stand in for whatever instrument that is, get access to data that's spread out over places, that's the interoperable question. They would like to have that. As an end goal, that would be sort of a stage three. I don't know how we'd describe that concept.

Deven McGraw – Center for Democracy & Technology – Director
We're watching the VA and Medicare now do this, and they've done it in six months or less, be able to provide information portability to patients. It's not purposed by any stretch, but it's a pretty good first start, and so I'm thinking, when we think about timely electronic access, leaving aside copy for a minute, but access. My concern in stage one is that if I am a patient seeing four or five providers, I'm going to have four or five portal, four or five different PHRs, and I have no way to get all the data in one place, but I can look at it easily. So I'm wondering whether or not, in stage two, if we can ask the vendor community what would it take to build that blue button capability into EHRs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Why don't we just use the pattern we had before? In stage three, you would like the world to look like what?

Deven McGraw – Center for Democracy & Technology – Director

In stage three, the patient should be able to upload structured data into one place of their choosing, one particular place of their choosing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They upload or have their information that resides in multiple places be accessible through one?

Deven McGraw – Center for Democracy & Technology – Director
That's the same goal. I think I'm just looking at it through a different lens. I'm not sure that I care whether or not it all sort of goes there or they choose where to pull from because, I think, having the information go there requires them to designate a place. I guess I'm trying to think about how that would be operationalized. It requires them to designate a place to every doctor that the doctor sends their data as opposed to it's linked to the EHR, and it goes into this clinician's portal, but then the portal has the ability for the patient to say, pull this and put it here.

David Lansky – Pacific Business Group on Health – President & CEO
We have a policy change. It's a philosophical question of whether we want to advocate for – three tiers of possibility: one is that I, the patient, can expect any provider, any eligible professional or hospital to let me download my data in a common format to me, to my PC at home or my phone or whatever. I think that would be a fair minimal requirement, and that's a blue button.

Deven McGraw – Center for Democracy & Technology – Director
Right.

David Lansky – Pacific Business Group on Health – President & CEO
The VA and CMS are already doing it, so we've got a precedent that makes it not extraordinary to request. The second tier up would be, I can designate where I want that extra file to go. Rather than to me, I send it to a vendor of some kind, HealthVault or whoever. That puts a burden on all the source systems to know how to route data to HealthVault or whatever set of outside vendors are. That might be an added burden. The third is to allow that record to be sent to another EHR or health professional product to be incorporated into a longitudinal health record. That seems like a big list. I'd be comfortable if we could achieve level one. I've at least got it myself, and I can then retransmit it to somebody else who I think might take advantage of it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Having that as stage three or two?

David Lansky – Pacific Business Group on Health – President & CEO
Two, I think that's— I don't know. I'd wait to hear what the vendors say, but I think that's pretty doable.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Again, I think vendors are at different states of doing this. It's harder, I think, at the hospital level than perhaps in the ambulatory setting. That real time word is a really important word. Some of the feedback was, again, there's downloaded one way, but you'd probably want to have it by patient preference or multiple modes of giving like if it's a USB, so keep some flexibility there. I think that's in the rule today in terms of how you make the data accessible. The list will be, can we get to real time by stage two because some people, some systems have architectures, which make that really hard to export the full record at this point in time. That was kind of the pushback I got when I talked to the vendor community about that.

David Lansky – Pacific Business Group on Health – President & CEO
I don't think real time is a critical consideration.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, so they can already do three or four business days, right, because that's what the requirement is today. Is that correct? I think the different between real time and three business days, I mean, it probably does really matter for some people.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
It could be overnight. It could be an overnight update to update another database.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. Great.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
That's kind of what happens in some cases.

Christine Bechtel – National Partnership for Women & Families – VP
That would be great. Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
David, I like the way that you describe the three levels, and I understand what you're saying in the first level: download it to my phone; download it to wherever for me as the patient. But isn't that third case from EHR-to-EHR what we're going to get to in care coordination? We may solve it with level one in this area, but we may get to level three in the other priority area, right? Did I get that right?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Again, then the other piece of this just to add onto that, there's data that we're being required to capture to be able to exchange today. That's the data that can become timely, so it may not be that whole record. Again, it's what you really ask for here. I think, if you leverage the infrastructure that's in place today, which is the ability to exchange this core set of data, go for it and let's try and make that as mobile as we can. If you want that whole record, it gets a lot harder. I think there's pieces in place with what's in stage one that help make some of that data mobile that's just really important data, and then we can add onto that. Again, that's another way to look at the problem.

David Lansky – Pacific Business Group on Health – President & CEO
How do we define the scope of the content that Charlene is describing for this task, for this element here? We say the electronic copy of health information. Are we saying it is everything, or is it …?

Deven McGraw – Center for Democracy & Technology – Director
We could use the definition that's in the rule now with respect to, I think it is the after visit summary, which is actually very comprehensive.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's very comprehensive.

Christine Bechtel – National Partnership for Women & Families – VP
Right, so we could say that by stage two, that data needs to be portable and able to be uploaded. Then by stage three, it's actually the record itself that needs to be able to be portable.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
For your intent. Your intent is to get there.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
So you can download the whole thing or however.

Christine Bechtel – National Partnership for Women & Families – VP
View it or whatever. Yes, right.

Deven McGraw – Center for Democracy & Technology – Director
Yes. I think we also need to keep in mind, there's an interesting interplay between what we're setting out in meaningful use, which is about patient access to, at least as we've defined it in stage one, relevant components of data like a care summary or a discharge summary versus what congress did in HITECH with respect to HIPAA modifications and the requirement to provide an electronic copy of a record upon a patient's request. HHS is in the process of implementing that and thinking about what should the timeframes be in that regard, which is potentially a much greater universe of information versus what we've made available in meaningful use.

What I'm still struggling with is what are patients most likely to find valuable. Is it the pieces of information that they're going to be able to get through meaningful use, which is a pretty critical set of data, or should we really be focusing on the whole enchilada, the whole medical record? Often patients will need that, particularly if they're transferring providers and going somewhere else. It's often an obstacle for them to do that, and so we want to make sure that that capability is there, but I'm trying to figure out what for meaningful use in stage—I think our stage two recommendation is right on. I'm trying to figure out what we really should be shooting for in stage three.

Then with respect to what HHS has said, at least in a proposed rule about the requirement that patients be able to direct that data to be sent where they want it is a recognition that if a patient has a HealthVault PHR, for example, and the provider doesn't have an interface to the PHR from HealthVault, there's not a requirement to send it there because it's not capable, and there's a negotiation that essentially goes on between the doctor and the patient about how we're going to do this. You have the right to get it electronically, but you don't necessarily have the right to have it sent to a PHR of your choice if we can't do that.

Then I guess the third prong of that is where are the major PHR vendors that are independent versus Kaiser has its own PHR, so obviously that's not an issue, with respect to how easily can they make those interfaces happen because there's a market pressure that we might try to build on here as well where you have a lot of companies with a lot of resources out there who have a vested interest in making this happen.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Maybe one way to do it is stage two is the blue button download, and it's ….

Deven McGraw – Center for Democracy & Technology – Director
Although a blue button is only applicable if you've got a portal, right?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Right.

Deven McGraw – Center for Democracy & Technology – Director
If you don't have a portal, and there isn't a requirement to make a portal.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
In stage one, you can do a test. We need to export this in stage two, right, and move to be able to import it smartly in stage two.

Art Davidson – Public Health Informatics at Denver Public Health – Director
But couldn't a blue button …?

Deven McGraw – Center for Democracy & Technology – Director
I don't see how a blue button works if there isn't something for the patient to enter into and be viewing. The download is just about can I get a copy of what's in front of me. The patient doesn't have independent patient access to the record. Josh is looking. Is there something I'm missing here? I don't see how you blue button download something when you don't have a portal type.

Neil Calman – Institute for Family Health – President & Cofounder
Why couldn't you download it to a USB drive, a thumb drive?

Deven McGraw – Center for Democracy & Technology – Director
Download from what?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Couldn't the providers offer …?

Deven McGraw – Center for Democracy & Technology – Director
Well, the provider can, yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
It's a blue button functionality that's not run by the patient, but rather, someone on behalf of the patient to generate whatever documents we're talking about.

Deven McGraw – Center for Democracy & Technology – Director
Yes, and that's actually what I think is already covered in the proposed rule, other than the timeframes, which are not the same, but they have said, if you're using an electronic record, and the patient is asking for data, which is stored electronically, and they want it electronically, you've got to find a way to make that happen. Whether it's on a thumb drive, whether it's on a PDF that's sent by secure e-mail.

Josh Seidman – ONC
Within three business days.

Deven McGraw – Center for Democracy & Technology – Director
Not in the HIPAA rule.

Josh Seidman – ONC
No, I'm saying in the meaningful use.

Deven McGraw – Center for Democracy & Technology – Director
In the meaningful use rule, right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Stage two is the downloadable, basic health information that's described, and maybe what you're proposing in stage three is that it causes the standards committee to create standards that says there is a standard by which the systems that hold this data can interoperate and conform to a standard so that they can be exchanged from one system to another, whether it's EHR-to-EHR, EHR-to-PHR, PRH-to-repository. There's a way that you exchange patient health information for this group of data.

Christine Bechtel – National Partnership for Women & Families – VP
And we're using the definition. We're using the data elements contained in the care summary definition, which are fairly comprehensive, so that the medium almost doesn't matter because everything is now coded structured data. It's not a flat file of some of ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't know whether everything in there is, but….

Christine Bechtel – National Partnership for Women & Families – VP
But what we're saying is if it's in stage two, going through the certification process, every data element that is part of that designed care summary would then become structured, right?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
There's what, three elements structured today, I mean of subsets structured today? In phase one, the … is pretty low. I mean, you could get by with a PDF in some cases, so you can export it, but it's in the format anyway. I think we need to get smarter in stage two.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, so it's structured data, and that's the recommendation that goes to the standards committee based on the defined care summary elements in the stage one rule.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
PDF is not structured data, nor per our earlier conversation is, let's say, medication allergy. We don't have that as structured. It is a code, but the code is known only to the individual institution. When we describe structured data, we mean sort of using industry standard so that it can be understood by all parties.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But we're nowhere close to that right now.

Christine Bechtel – National Partnership for Women & Families – VP
For the defined elements.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For the defined elements.

Christine Bechtel – National Partnership for Women & Families – VP
I wish I had the ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
For lab tests, problem lists, and medications, we probably are there, but your point is that for medication allergies, we're not. Is that right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They had vitals, reason for visit, that's another one that's not structured.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Meds, lab test orders, procedures, updates to problem lists, immunization meds, instructions, next appointments, symptoms, a lot of stuff that isn't structured there ….

Christine Bechtel – National Partnership for Women & Families – VP
…standards around it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Doesn't have standards.

Christine Bechtel – National Partnership for Women & Families – VP
How …?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
The vendors are taking the steps to structure those key elements, the medications because we know what they are, the labs because we know what they're tied to. We know we have to go towards SNOMED, but it'll be ICD-9 or ICD-10, so work is happening in the vendor community to begin to structure the data necessary for exchange, so we should leverage that, right? But it's not all the elements that are part of the ….

Christine Bechtel – National Partnership for Women & Families – VP
Can we get there by stage two?

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
I don't think we can get them all because the standards aren't defined yet to be able to do that. But there's a minimum set of important data that you could start to structure, that you could start to exchange in stage two.

Christine Bechtel – National Partnership for Women & Families – VP
Then everything else that doesn't have an associated standard could be like the VA and Medicare have it now where it comes out, I guess, in a flat file, and the vendors have shown that they can figure out how to work with that data. Is that right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But how structured … data?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Structured … pull it up ….

David Lansky – Pacific Business Group on Health – President & CEO
It sounds like this goes to the standards committee as well. We need to chart a path for the next four years.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
A glide path ….

David Lansky – Pacific Business Group on Health – President & CEO
…proportion of CCD or equivalent data extracts that conform to some standards.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I would say we need to structure what needs to be structured and not say we need to increase to a certain level because I don't know what that level is, so we need to structure what should be structured. These exercises often end up in totally structured.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I kind of like what David said. Why don't we try to leverage what is structured inside the CCD and not try to do anything more than a feature that should be part of all EHRs in the very near future. Isn't that where we think we should be leveraging that effort?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I want to help the patient, so I want structured data that's structured. That's great. If it's not structured, I still want the data to go over because I want the patient to figure out what's wrong with them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the term actually semistructured, which describes what you just said, which is where the standard codes exist, transmit it that way so everybody can use that information. Where it isn't, it should be, one, put in a field where it can go in that same field, even though the machine can't understand it. Importantly, that it be human readable, so that addresses, let's make it useful to the patient even if, in stage two, we cannot have it go to all computers and be understood. So maybe that's ….

Neil Calman – Institute for Family Health – President & Cofounder
…of a patient instruction or something like that would fall into that category or progress notes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. I think what we want to do in stage two is get it out of the system, the "blue button" and in human readable format that's available electronically. In stage three, we want to be able to accumulate all the information in the various systems in a standardized way to the extent the standards exist at that point. What we're trying to do is encourage more of the standards to happen between now and 2015, so as much as can be structured in a standardized way will be.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Or ought to be, not that I can be. First of all, I wanted to get some of this down, so are we fixing 35?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, we're fixing ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Which one are we on? Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Forty.

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
Forty.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Forty subsumes 35, no?

Christine Bechtel – National Partnership for Women & Families – VP
Actually, I'm thinking of this actually in the context of 43 because and, Deven, tell me if you think I'm off on this, but copy is really the copy of the record that the provider holds that should have lots of historic information. I've been a patient for 20 years, and it should come with sort of like, right, that's what we think of as a PDF scanned and copied of a medical record, like the information that would maybe be in that.

This is something that is already, as Deven has pointed out, a requirement under the law that where meaningful use really adds value is adding the three-day requirement. Electronic access, as we discussed it early, was really about the ability to have a view into the record and then ultimately be able to move that information, but it probably focuses more on the most relevant information and not everything over the past 20 years. To me, that's the distinction between copy and access, at least as we're talking about portability. When I'm talking blue button, I'm really actually thinking about 43. Ultimately, hopefully, we will not have to worry about 40, an electronic copy, because, in 30 years, there will be no remnants, right? But ….

Charlene Underwood – Siemens Medical - Director, Gov. & Industry Affairs
So does 43, are you just raising the bar with 43?

Josh Seidman – ONC
Forty-three is the online portal access. Yes, you're right in terms of 40 really being the extension of the HIPAA.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the answer to her question, I thought this too. If everybody had access, does that satisfy 40?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
No, because the process you're automating is the old, manual process making sure you have your medical record to take it from one site to another.

Christine Bechtel – National Partnership for Women & Families – VP
The whole thing.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The whole thing, so that's ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Which one is that, 40 or …?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's 40.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's 40.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I need a copy of my record because I'm going to change docs, or I want to take it for a second opinion.

Christine Bechtel – National Partnership for Women & Families – VP
I think it was confusing to people because, publicly, people interpreted copy and access very differently. And so when we said access, many people read that to mean simply a view in, but you can't move it. You can't take it. You can't do anything with it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right.

Christine Bechtel – National Partnership for Women & Families – VP
And you don't get – there's no certification ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You can't download it or anything.

Christine Bechtel – National Partnership for Women & Families – VP
And I think that wasn't what we intended, so the blue button notion is really, and I wish we had a better word than access here, this notion of taking the information that I've used for our portal, which is mostly my most current information last year … three years, and being able to assemble that in a place that, over time, will become more longitudinal and may make the request for copy happen less often. But as Deven has pointed out, if you're going from one doctor, and you're changing to another, you really do need a copy of the entire record.

Deven McGraw – Center for Democracy & Technology – Director
I think our ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The final rule doesn't talk about the final record. It lists the few things that are included under copy.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And also, it only referrers to what's an electronic record. It's doesn't cover anything that's on paper.

Deven McGraw – Center for Democracy & Technology – Director
That's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I read 43 as having two important words. One is timing. One is access. Access is any time. A copy requires some staging before you get this copy you can hold in your hand virtually. The access is any time I can immediately access, and the other thing is timely. That's where the four days comes in. You get provider four days to go through your process of seeing it and so on and so forth, and then I get access. Do you see what I'm saying? Those are, I thought, the dimensions for 43.

Christine Bechtel – National Partnership for Women & Families – VP
That's also true.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
The way that we're conceptualizing the distinction between access and copy is not the way it's distinguished in the law. Access is you're looking at it. Copy is, you grab it, and you've got something that you can take with you. So, to the extent that we're talking, and maybe what we need to do is stop thinking about this in these increments because we seem to be getting wound around it, and start thinking holistically in terms of patient's ability to access and have a portable copy of electronic health information in the most expeditious way possible. When it's a portal, there ought to be a way to download the data. If you don't have a portal, you ought to have a way to transmit it electronically to patients through some other mechanism.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There is access. There's timeliness. Then there's the ability to cause exchange. Does that cover it?

Deven McGraw – Center for Democracy & Technology – Director
I don't know why we keep making this distinction between what is mere access and what is an ability to have it in a portable function. I don't understand why we keep thinking of those conceptually as two steps. I'm not sure that just being able to take a look at something is terribly useful. It's not bad as a first step. But in later stages, I'm struggling with why there's this conceptual process function when, in an electronic world, that ought to almost be subsumed into one.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
EHRs today, doctors can read the entire thing, but they can't make a copy of it very easily.

Deven McGraw – Center for Democracy & Technology – Director
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So they care for patients through what Paul is calling access without ever making a copy. That's just what EHRs do well today.

Deven McGraw – Center for Democracy & Technology – Director
That's right, but that's the physician's record. When we're talking about what a patient needs, I'm not sure that that distinction between access and copy, I mean, maybe it's when you're just getting a lab

result, and you just need to see the word negative. You don't actually care if you get a copy of it or not. You look at it, and you close up your portal, or you close up your PHR, and that's the end of the game. But I'm just struggling with why we see this in two stages where the patients are.

Christine Bechtel – National Partnership for Women & Families – VP
I guess what I'm wondering, and I haven't fully thought through the implications of this, so this may not be the right approach is, should we consider eliminating the distinction between copy and access, period, and simply going with providing timely, electronic, I don't know if we do copy and access or we figure out what the words are. But that ….

Deven McGraw – Center for Democracy & Technology – Director
Access with portability.

Christine Bechtel – National Partnership for Women & Families – VP
Right, timely, portable access to the health record, and we say within three days, so that would still cover 40, at least the timeline on 40, and we still have the law, which separately requires that, although it doesn't put a timeline on it.

Deven McGraw – Center for Democracy & Technology – Director
Yes. No, in proposed form, they asked for comment on that, so we don't know what that will turn out like.

Christine Bechtel – National Partnership for Women & Families – VP
But if we cover it by saying, by really combining the two concepts, and we keep the three-day piece, I believe access is within four days of availability to the practice. How do we get to a place where we can …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the reason we're trying to use different words is I think they're different functions, different standards involved, and different goals. For example, most people do have access, i.e. humanly readable. That's fairly straightforward. Most people, almost nobody has the transfer, the guaranteed transfer to another record system, and that's the reason for distinction between those two because you know where you are, and you know where you need to get to, and you know what it takes to get there. If we combined it in one word, we wouldn't be able to track people on their glide path.

Christine Bechtel – National Partnership for Women & Families – VP
But copy isn't exchange anyway.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. That's why I said there's access. There's timeliness, and there's exchange in this 43 context. And if you had all three, you would meet Deven's criteria. But it's hard to put them all in one word and say you either do or don't since there's value for these other steps. That's the only reason to define them in words.

Deven McGraw – Center for Democracy & Technology – Director
Yes. It's sort of silly to argue whether it needs to be three steps or two steps. Let's think about the outcome that we want because I guess I keep getting to the point that for physicians, they don't always need copies. The record is there. They can pull it up at any time. Because what the patient is asking for is data that's not in their hands, it doesn't get in their hands just by looking at it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They make use of it.

David Lansky – Pacific Business Group on Health – President & CEO
…two different models here. One is, I think the portal model where the patient looks at a piece of data and is done is a valid model, and many, many patients will probably never do more than that. There are many patients who really want custody of the record copy and can do a lot of things with that. Whether

we need to require – we are already going in the direction of saying both of those functions should be available to people to be able to go to the portal of my provider and look at some data and be done. If I want, I should be able to capture a copy for my own use.

Deven McGraw – Center for Democracy & Technology – Director
Right. I don't think we're disagreeing on any of that. I think it's just how we ….

David Lansky – Pacific Business Group on Health – President & CEO
But to clump them together ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
To clump them together makes it hard.

David Lansky – Pacific Business Group on Health – President & CEO
I think there are two different functions here. It's okay to keep them both in the rule.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It violates Charlene's specificity requirement, which is ….

Deven McGraw – Center for Democracy & Technology – Director
Keep it separate, and then tell me what it looks like because I'm still having a conceptual problem with thinking of this as two meaningful steps for consumers.

David Lansky – Pacific Business Group on Health – President & CEO
Actually, if you look at the sample blue button download from the VA, it makes clear how different they are.

Deven McGraw – Center for Democracy & Technology – Director
Yes, but you have the ability in every instance to be able to download that. So it doesn't mean that—so the access and the download are all part. They're two different steps, but the functionality is there with any visit as one functionality.

Neil Calman – Institute for Family Health – President & Cofounder
Isn't this sort of like going to a Web site. I mean, you can access … for download?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't disagree exactly what you're saying that it's probably going to be an evolution to some extent to get there. That's all. I think that's kind of what we're struggling with is because they're separated processes today, and now we're merging them together.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We've got some old process that we're dealing with.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We're going to create a copy for the patient and hand it to them, so that's why it was separate. Either the patient could go online and go on a Web site and look at their record, or the doctor would create a CD or a USB drive and hand it to the patient. In the future, where the doctor doesn't have to do anything, and the patient just pushes a button, then in fact it's the same user interface, whether you're accessing and pushing the button, and then they put it on the UBS. We're basically taking the doctor out of the loop eventually.

Deven McGraw – Center for Democracy & Technology – Director
Hopefully.

Christine Bechtel – National Partnership for Women & Families – VP
What we're saying is leave copy in as is, and we'll figure out for stage two should that be a higher threshold or whatever. But for timely, electronic access, we need to describe it in a way that indicates portability.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Which number?

Christine Bechtel – National Partnership for Women & Families – VP
Forty-three.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…think about this.

David Lansky – Pacific Business Group on Health – President & CEO
…take me backwards. I was going the other way.

Christine Bechtel – National Partnership for Women & Families – VP
Where were you going?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
What did you recommend?

David Lansky – Pacific Business Group on Health – President & CEO
I thought copy meant portability and access doesn't.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's what I did. I thought that.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And the question on portability was just real time in the near term.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
When you copy from a Web interface, it's also timely because you push the button, and you get whatever is current. It's a little bit different … doctor to prepare the CD, which takes four days.

Christine Bechtel – National Partnership for Women & Families – VP
I like that, but in all fairness, I will point out, electronic copy of health information is a copy in the record within three days of the request. The access, if we added the portability dimension, is within, I think it is, four days of that information being available to the practice, which is distinctly different, and I think probably in some ways less timely than as soon as that thing is in the record. If I've made a request the day before my lab was in the record ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In your terms, the three days would occur after the four days.

Christine Bechtel – National Partnership for Women & Families – VP
No, I'm saying the three days could occur before the four days.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, but there are different purposes. The four days was to make sure that someone looked at this information and had a communication with you, as appropriate and, at the latest, four days, it would show

up in the record that you can access. There's a processing of the information step. That's what's built into that. It's not a minimum. It's a maximum. But at that four days, it gets put into the record that becomes accessible to view one way or another.

Christine Bechtel – National Partnership for Women & Families – VP
Within three days of my request, that's what the three days is. If my lab result comes back to the practice on day one, they have to make that lab result available to me within four days. But if I ask for a copy of my record, they've got to make the record available within three.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But you won't get the lab results.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…talking to you at 3.5 days, you might beat the doctor ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Actually, that could be a problem for you because that lab result would be there.

Christine Bechtel – National Partnership for Women & Families – VP
I know.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You know that, don't you?

Christine Bechtel – National Partnership for Women & Families – VP
Right. Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I know, so she ….

Christine Bechtel – National Partnership for Women & Families – VP
I hate to point that out because I think it behooves the patient to get that, but I feel compelled.

Deven McGraw – Center for Democracy & Technology – Director
The good news of all of this discussion, I think, is that I think we're at least coalesced around an outcome goal that we want patients to be able to quickly access and have a portable electronic copy of health data, relevant health data, the whole record, I think, is another issue. But in terms of the pieces of data that are part of this care summary, for example, or the discharge summary. I think, rather than quibbling over whether it's access or whether it's copy, we should just take some time to work backwards from that goal, figure out where we got in stage one, and what's the right interim step and what's the …. I'm having a hard time doing that on the fly. But it should, with a little bit of drill down, not be terribly complicated.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The whole reason it got split up is because it is complicated. In stage one, we were shooting for the same goal, and then we got ino this same discussion and realized there were different timelines. There is a difference between access and ….

Deven McGraw – Center for Democracy & Technology – Director
Yes. I'm fine with applying different timelines. I get that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
But I just think part of what we're struggling with is not just the substance, but tripping up over whether something is called access or whether it's called copy.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But the reason is because that's how it's manifest in the system. If we don't make it specific, if we just said portability and handed that to the vendors, they won't.

Deven McGraw – Center for Democracy & Technology – Director
No, we can't just say that. I'm just suggesting that – I guess what I'm suggesting is to take this off line and try to work ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Agree.

Deven McGraw – Center for Democracy & Technology – Director
And Christine will figure it out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In the end ….

Neil Calman – Institute for Family Health – President & Cofounder
I really appreciate the confidence.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In the end, at the stage three column, we're saying 90% of patients should be able to do what you wanted them to do, and we'll try to make that happen between now and 2015. Are we on track?

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good.

Deven McGraw – Center for Democracy & Technology – Director
I think so. I think we need to do so mindful of the concepts and the concerns that we addressed in stage one, such as an ability for patients to get counsel on lab test results, but not have that dragged out ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
And I think we have to think about the sort of technological and health trends, so I'm thinking about this also in a way that facilitates connectivity to mobile apps for health so that I can facilitate more patient power and patient activation, right? It's not just I want to move my data bits around.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. That's why we have to take it in stages and define what we mean, which data fields we mean so that we can be as precise about which ones have to be structured so that your applications can take advantage of that. If you can go, scroll left a bit, George, we can look at ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Where?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Left.

Neil Calman – Institute for Family Health – President & Cofounder
Paul, can I just ask a question?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Absolutely, Neil.

Neil Calman – Institute for Family Health – President & Cofounder
I've had a concern about the issue about language, and I'm wondering if anybody has been talking about that. I'm not sure whether this is HIPAA or Civil Rights or whatever. But it seems to me that we're creating something that we think adds tremendous value to people in their healthcare. At least when somebody walks into a pharmacy or a doctor's office, we have certain requirements to produce things in appropriate language. But we really haven't talked about that in relationship to these kinds of documents that we're producing.

I think we should at least signal the fact that there's some things that people need to start working on that enables people to get this information in their preferred language, not to go beyond what the requirements are in law already, but to just make sure that we're not moving things backwards, because I think that's a huge disparity issue if we basically say you have to provide translation. You have to provide all this stuff. But it's okay when it comes to electronic information to just get it in English. I think that's a step backward.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Don't we have at some point …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was looking for it. I know I've seen it before.

Neil Calman – Institute for Family Health – President & Cofounder
If you scroll down, I think it might be in 45 where we talk about patient specific education resources.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
That's … patient specific education … understand for all the information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's talk about safety. Ideally, of course, we'd want it to be in the primary, a language that the patient understands. What would be our expectation, let's say, in 2015? I suppose it can't be all ….

Josh Seidman – ONC
Yes. I'll just say that in summarizing things on the table, sort of groups, the overall, it came up in both the patient family engagement hearing and in the disparities hearing basically trying to make this available and understandable. It also came up last week at the Health IT Policy Committee meeting when we had testimony on accessibility issues, so it's basically that issue of making information understandable to whoever the population is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Josh Seidman – ONC
Instead of listing it everywhere, if you go down, I think, a couple lines to 45, I think it's just summarized there once. But I agree with Neil that the testimony came up in each of these places.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is there a way that we can describe stage three, i.e. 2015, and ….

Neil Calman – Institute for Family Health – President & Cofounder
I have a suggestion about this, which for coded information, it's easy to uncode it in another language. A machine can do that fairly easily. It protects information. Obviously that's a whole other technology. But if you code, for example, if you code a problem list or code medication names or code … or code instructions for how medications are delivered, those things, which are coded, then I think you can uncode them in another language fairly easily. I think the technology is there to do that. The question is what would we want to signal that people should be working on in order to make this happen?

David Lansky – Pacific Business Group on Health – President & CEO
It sounds like the capabilities that we're talking about back up to the last discussion about patient information distribution provision is that that be enabled with multiple language support and it doesn't have to be responsive to the needs of the particular patient. Then we have to find some realistic framework to put that in terms of number of languages and priorities. But having it only in 45 sounds like a different category of stuff rather than having it influence all the patient supplied information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't know if we can either modify 45 to make it apply to everything up above, or we could modify the language we use in 41 and 43 to say such that the patient can understand it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And this may be where there's a bit of a list because if you think about discharge instructions and that kind of things, there's software out there that makes it patient friendly in the appropriate language. And we start to go across the whole record. That's a super climb, so it needs to be part of that framework. During the blue button and giving them access in rudimentary form is one set of stuff, which is much more straight. To get it to real time, again, there are some hoops that have to be jumped, but then getting it to be patient friendly, which is kind of what the goal is, in some cases it'll be a lot harder for some of these. The discharge instructions, you already want to move there to be patient appropriate. There are some pieces that there's software out there to do. The other ones, there'll have to be some development linked to.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I wonder if that's a parking lot. Maybe … can help us figure out what's feasible.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Maybe on this line, if we go to line 42, we could make a little progress with what Neil is saying in stage two since somebody is saying it's relatively there already.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
There's products you can purchase in the market in some of these spaces that people have built those types of things.

Art Davidson – Public Health Informatics at Denver Public Health – Director
That it'd be language concordant. We'd make some progress in language concordance in sharing information maybe for line 42, maybe even for line 43. Ultimately, we'd like to see that happen for lines 41 and whatever line that was, 44.

Deven McGraw – Center for Democracy & Technology – Director
Forty-four is education resources.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Sure, that one too, but the one where we were having a discuss about access versus copy and just say we're just going to do little pieces of that for, as Neil points out, for the people who are not English proficient.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Educational resources is where there's support today. You've got to purchase them or embed them or whatever.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Speaking of which, we haven't done a great job at sort of – so we up for some interim editing, we passed on the copy and access, and so we'll put out some kind of draft for stage two if percent is the way we handle the interim ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
In column 46….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…my notes on that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The EHR … exchange data with PHRs, but is it PHR health information? It seems like PHRs is one media as opposed to ….

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Where are you?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Line 36. I don't know what's in ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
This red thing means we've got to figure out what we're doing with the next five lines. It just says you can read it as a chart. You can download a subset. You can download the whole chart. You can transfer it to something else like a PHR. We have to figure out things like what delay for clinicians to review, which is independent of the electronic limitations. And, three, the language you review it, and those are things we have to come up with what we're doing with access and copying in four years. That would cover line 36, line 41, and line—if I got that right—and line 44. I'm hoping … 42, I just added the fact that it's a language. Discharge instructions are different than looking at the chart. These are like preventive reminders, more analogous to those than to looking at your chart. These are targeted to you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do people agree with the 90% in the top five primary languages in stage three?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What would we like to do in stage two?

Christine Bechtel – National Partnership for Women & Families – VP
With respect to discharge instructions, the thing that sort of fits in the consumer … the most here is that they are not offered. They are only upon request, so the patient has to know to ask for them to get them

electronically. The first thing I'd like to see is that every patient is offered a copy of their discharge instructions electronically.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
How are you going to measure that?

Deven McGraw – Center for Democracy & Technology – Director
…we measure a lot of stuff ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
…huge … system was just anything that related to an ask system was struck from the rule.

Christine Bechtel – National Partnership for Women & Families – VP
But how are we measuring whether it was provided upon request? You have to measure the total number of requests, and you have to then calculate a 50% numerator off of that. It's a pain either way.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It is a pain.

Christine Bechtel – National Partnership for Women & Families – VP
So let's get it right and do it through attestation.

Neil Calman – Institute for Family Health – President & Cofounder
When would we not want to issue discharge instructions to a patient?

Christine Bechtel – National Partnership for Women & Families – VP
Neil, your phone is like it goes away and comes back.

Neil Calman – Institute for Family Health – President & Cofounder
I'm sorry.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think there are a lot of situations where it's just not appropriate because of the patient situation.

Christine Bechtel – National Partnership for Women & Families – VP
That they would not be offered, they should not be offered …?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
No. That could possibly be too.

Josh Seidman – ONC
Neil asked when would you not want to—

Neil Calman – Institute for Family Health – President & Cofounder
Not want to, yes.

Josh Seidman – ONC
--provide discharge ….

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You always get your discharge instructions, but there are probably lots of cases where you just give them a piece of paper. That's the discharge instructions rather than an electronic copy because of the family, the patient, those types of situations.

Christine Bechtel – National Partnership for Women & Families – VP
Right, so all I'm suggesting is that the hospital simply say here's your discharge instructions on paper. Would you like them electronically, because it makes it so much easier for caregivers to be able to assemble that information? They lose the paper, and they've got 10,000 pieces of paper they're coming home with.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Give me your e-mail, and I'll send it to you at home.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Securely.

Deven McGraw – Center for Democracy & Technology – Director
Securely, of course.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Absolutely.

Neil Calman – Institute for Family Health – President & Cofounder
Yes, without your name on it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Clinical summaries is defined differently than discharge instructions, and I don't know why. The clinical summaries, you have to offer it, whereas discharge instructions, they have to ask. I think that's probably an inadvertent inconsistency.

Deven McGraw – Center for Democracy & Technology – Director
I don't know because we certainly commented on it loud and clear in the NPRM, and it didn't change. But if everybody is comfortable with that changing, I think that would be a better step forward.

David Lansky – Pacific Business Group on Health – President & CEO
I don't think we agree on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Stage two starts out offer to—so what's the percent here?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm just going to start writing this even if it's wrong.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, the word —offered" is in stage three definition.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, that's yours, not the rule ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…Christine.

Christine Bechtel – National Partnership for Women & Families – VP
I knew you were, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What's the percent, 50%?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
I think it's at least that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is just our draft to go get comments on. Then we did clinical summaries, and clinical summaries is given to patients at each office visit. Now this is the one that's fairly expansive down to the symptoms. I'm not sure if anybody does this right now.

Christine Bechtel – National Partnership for Women & Families – VP
No, and this is one of the most important things for patients, so I think certainly you can increase the threshold so that it becomes even more patients, and I think then we have to figure out, and maybe this is covered in the access piece how to make that information more portable. I think, in the rule right now, it can be electronic or on paper actually, which I think is fine. I mean, this should continue to be appropriation preference, but having that information. There's also, I think, Josh, if you can remind us, within a certain time limit. I think the practice has a couple of days to give the patient the visit summary. Is that right?

Neil Calman – Institute for Family Health – President & Cofounder
Three days, I think.

Josh Seidman – ONC
Clinical summary?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
Three days.

Christine Bechtel – National Partnership for Women & Families – VP
In an electronic environment, if we are thinking about the information that we've just discussed capturing earlier under the first bucket: vitals, etc. Does the practice reasonably need three days to prepare the visit summary, or could it be something that in stage two or stage three is really given to the patient at the visit?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, but is this in terms of what they mean by clinical summary?

Christine Bechtel – National Partnership for Women & Families – VP
It's in the rule, so it's all the data elements in the rule. Do you have …?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Clinical summary if it was through data elements?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Josh Seidman – ONC
In the certification.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I have it right here.

Christine Bechtel – National Partnership for Women & Families – VP
It's good.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Diagnostic test results, problem lists, medication lists, medication ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This is why we have to have a real time one because of that.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Copy of the record … it's in the ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
These are the things that are driving currency of the data because you've got to have, to print this out, you've got to have a capture of it.

Christine Bechtel – National Partnership for Women & Families – VP
Right. My question is, if we've defined the clinical summary, we've defined the data elements that have to be in the clinical summary, and the providers have three days to deliver that, and the delivery can be per patient preference, is there a reason that providers need three days, or can that be in fact at the visit if they're capturing all this data in real time, as they should be?

Neil Calman – Institute for Family Health – President & Cofounder
This is Neil. I don't think there should be a delay. I mean, the after visit summary for an ambulatory visit is relevant at the point of view, not only because the information is …. I'm sorry. Can you hear me?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Deven McGraw – Center for Democracy & Technology – Director
No ….

Neil Calman – Institute for Family Health – President & Cofounder
I'm sorry. It's not only relevant at the point of care, but also because it's also as it's printed or delivered to the patient, it's something that you can go over: a medication list, a problem list, a set of next appointments, what the orders were. The things like that are often the subject of discussion and then handed to a patient or, I guess, also you could send it in electronically. But the point is that it is available, and I think three days later it's not as useful. You're changing somebody's medications, and you'd like to hand them the list of their new medications, as well as pointing out the new ones and the ones they should be stopping and being able to give them that information as they leave is really critical.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are you suggesting a change in the percent threshold and the timeliness?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. I think timeliness in ambulatory care visits should be what's available at the time of the visit.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What would you like to propose?

Christine Bechtel – National Partnership for Women & Families – VP
Let's go to 65%. I don't know what's realistic, so we'll get some feedback, but 65% of patients get a clinical summary at the visit before they leave the office. Neil, does that sound doable?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I thought Neil was advocating for a shorter timeframe, and is it about a greater percentage of people getting these clinical summaries, or is it about getting it done the day that they're being seen in the clinic?

Neil Calman – Institute for Family Health – President & Cofounder
It's about both, definitely both.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Then some people don't want this, so are we judging people for what the patients don't want to take away when we start raising this to 65%?

Christine Bechtel – National Partnership for Women & Families – VP
I'm not sure that there's any patient who is going to say I don't want a summary of what happened, even if it's a piece of paper versus the electronic. I think they're going to express their preference on delivery, but I guess I haven't heard any issue with people saying, don't tell me what my visit was about.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Some people may walk out knowing what it was about without needing to be reminded on some ….

Christine Bechtel – National Partnership for Women & Families – VP
Right, but it's like you get a receipt for what you just paid your copay for. Right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
They may not want that piece of paper.

Christine Bechtel – National Partnership for Women & Families – VP
Fine, but all the system knows is did you print it out or not. It doesn't know whether you put it in the recycle bin.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Didn't want to go there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But is that what we want to encourage?

Christine Bechtel – National Partnership for Women & Families – VP
I think that's the problem. I'm not sure that that is a problem that is worthy of solving is what I'm suggesting. I'm not sure it's even a problem that you have a massive amount of patients who don't want a visit summary.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
More than half of our patients are online with us. They have no need to have an additional paper printed out, and in the whole killing trees thing ….

Christine Bechtel – National Partnership for Women & Families – VP
Right, but this is not – no, I'm with you on that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And papers that are left on the chair.

Christine Bechtel – National Partnership for Women & Families – VP
But this is not about ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And who is the liability with.

Christine Bechtel – National Partnership for Women & Families – VP
But this is not about the format. This is a clinical summary that is delivered via the patient's preference, which could be paper, could be electronic, could be whatever. I'm not getting at preference here. I'm getting at, I don't think there's a problem with people not receiving a summary, whether that's electronic or paper. This already accommodates for that. I

n stage one, it already says they get it as a summary per the patient preference, and it's 50% of patients do. What I'm suggesting is 65% of patients should get the summary, and they should get it on the day of, whether it's delivered on the day of through their portal or their e-mail or on a piece of paper is already accommodated for in the rule.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The clinical summary does say per patient preference?

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So you would just judge that it was produced. So if it was electronic, it would be produced 100% of the time.

Christine Bechtel – National Partnership for Women & Families – VP
Delivered, I'm saying, it's delivered.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If it's electronic, it would be delivered 100% of the time.

Christine Bechtel – National Partnership for Women & Families – VP
What do you mean?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Once the information is in the record, then it's available to the patient.

Christine Bechtel – National Partnership for Women & Families – VP
But it doesn't go out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…form ….

Christine Bechtel – National Partnership for Women & Families – VP
What?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It includes lab data received no later than 24 hours after the visit is complete, so if you get it right away, you won't be getting that last 24 hours. It's written as if this was coming later on. That's all I'm saying.

Christine Bechtel – National Partnership for Women & Families – VP
It is, because they were waiting for the lab results to get in.

David Lansky – Pacific Business Group on Health – President & CEO
It sounds like our goal is to have the patient … use this word, have access.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Access to the record, right.

David Lansky – Pacific Business Group on Health – President & CEO
And some patients will be happy to never receive anything, but go to the portal when they want to, and it's always there, like your bank account. Some people will want to receive a secure e-mail or a USB or some piece of paper. If we can accommodate patient preference and find consistent language in here, which is … we have provide in one cell, offered in another cell, and we had just talked about delivered. But if we clarify that the patient can receive, can see, can have the clinical summary within 24 hours, whatever language we stipulate, of the visit by the means of their preference, and then list some of those means that we're talking about, that would cover it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. It's complicated. In a sense, we're revisiting what we talked about last time because there are so many attributes.

David Lansky – Pacific Business Group on Health – President & CEO
Active, passive ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Active, passive, access, copy. In theory, you would like to know what happened during that visit, and so does the physician. But you actually don't find out until the test, some of the information comes back. Then that completes, in a sense, that visit. This is sort of mirroring that process, which is why you don't get everything that was relevant to that visit the minute you walk out the door.

The other piece is that, in the process of seeing patients in the office, you may not finish everything until the end of that session or that day. That's another reason why the encounter documentation is not complete the minute you walk out. We try to give you as many things, like the orders have to be there, obviously. There are certain things that you need to walk out with, just like discharge instructions. But then there's sort of the completely the rest of the work that may not happen until the end of the session or the day. The goal is to get you what happened during the visit, and that's the reason that there's a difference in timing.

Christine Bechtel – National Partnership for Women & Families – VP
I think what I'm realizing, and I know, by the way, that Neil has a lot to say about whether you make people document in the visit or let them document later, and I know he has experience with that. But what I'm realizing is that if part of the premise, I know we're going to have the conversation offline or separately anyway. If part of the premise for looking again with fresh eyes at copy and access is that we would make some of the portability hinge to the very definition of clinical summary that we're talking about, then there may be an opportunity for parsimony here, and I think we ought to take the three sets as a whole and figure out what's the right construct to achieve all the goals that we're trying to articulate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We started there and found out that they can't actually all be done with one functionality, which is why we split them up, and we gave them different timelines because their availability or not and lack of variability.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Another piece of the parsimony, and this is really hard to decouple, is that care coordination has some of that other functionality, and to be able to connect these pieces. This transcends like once that data gets out there, then we can exchange it, and the data set needs to be the same. It's like all these pieces need to come together, and there are multiple pieces of this information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Where are we with this? We've talked some about the timeliness and with that caveat in the sense of what you are able to walk out with may be different from what's available in a matter of whatever the

turnaround time for some of these results is. How would you write it? What do you walk out with because we obviously can't provide you with the results?

Christine Bechtel – National Partnership for Women & Families – VP
I think what I'm suggesting is that in the same conversation we have where we take another look at copy and access, we include clinical summaries in that discussion as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're going to have to go at this again in our call.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We'll try to figure something ….

Christine Bechtel – National Partnership for Women & Families – VP
…do some work ahead of time. When is our next call, by the way?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it's October 5th. The next one is the patient specific educational resources. Am I on the right row?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is at 10% right now, and the proposal is to go up to 80%. It turns out, this is one of the questions that I asked Tony. This is one of the areas where it's probably not only likely, but highly likely that the EHR vendor is not going to produce the patient resource that the provider wants to release. That's the same thing as saying what you want to do to satisfy this is not certified, which also means then you're going to have to become certified with the kinds of patient information that you ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Actually, we got some clarity on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you? Good.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It sounds like, and I'm getting this secondhand, so maybe someone here knows better that the embedded stuff, we don't have to certify. That doesn't have to be certified to embed content, so where we're embedding elements to create the outcome, the EHR has to be shown that it will enable it, but that element doesn't have to be certified.

Christine Bechtel – National Partnership for Women & Families – VP
But also we have the HL-7 info button standard too, Josh. You probably are better equipped to talk about that than I am.

Josh Seidman – ONC
Yes. But we didn't require the standard, the … button standard, and so there's this issue that we have. Products that are going to be embedded or going to be, in a sense, referenced, that is, that the product being used isn't actually going to have the data in it. And so that's why it may not be able to be certified. So it's going to be a little bit of a challenge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. I guess the question is, can we as a provider get the system to link to information resources that we endorse and approve, or does that mean we automatically now have to get certified separately? That's our problem because this is one where it's likely to happen.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We'll give you a portal, and you can just link to what you want.

Josh Seidman – ONC
We're dealing with this issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The answer is not known yet? Okay. Yes. That's one of the reasons presumably this is at 10%. Now going … 80% reasonable in stage three.

Christine Bechtel – National Partnership for Women & Families – VP
Well, assuming this issue works out, sure, but I think ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't think I want any educational materials on my average millionth visit to the same doctor, so what's the denominator? The ones that need it or just your average visit where you don't need it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's really good.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I mean, it's offered, so I can say no, but ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is this one where they said relevant when we had a chance to say something?

Josh Seidman – ONC
Let me look up ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The qualifier was if appropriate. So that does make sense, but I don't know how to measure the denominator then.

Josh Seidman – ONC
Right.

Christine Bechtel – National Partnership for Women & Families – VP
We're raising all these issues now, but we have to know how to do it in stage one, so how are we going to do this in stage one?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, it's being worked on. That's what we're hearing.

Christine Bechtel – National Partnership for Women & Families – VP
I don't ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's figure out, can we help them work on it for stage two and three? I think maybe what we're saying is it's more that, one, you have the capability and, two, it's available then that you have to do it with every encounter because that's one of those forcing people to do something when it's administrative rule rather than what we want to is when we have something to say, we want it to be tailored as much as possible to their individual situation and in a way that they can understand it.

Christine Bechtel – National Partnership for Women & Families – VP
We want the provider to remember to do it too, right, because you have lots of features and functions in EHRs today that they just don't use because it doesn't fit into their workflow. They may or may not see value, but it just simply doesn't fit into their workflow. They don't think to do it. The payment model doesn't support it, lots of reasons. I hear what you're saying, and I think we certainly don't want to be harassing patients at every visit with, yes, I know I gave you that last time, but I've got to give it to you again because the federal government is making me. I get that. But I don't think it's sort of safe to assume that if we say, okay, you've got to have this capability, but don't have sort of a use demonstration, I think there's got to be an interim.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You have a lot of trees on your shoulders.

Christine Bechtel – National Partnership for Women & Families – VP
You can have it online. You can send me a link. You can deliver it in 2015 to my iPhone or Android or whatever, right? It's not. You're thinking with the generation of paper here. I'm not. I had to get one back. Come on. You were wide open. Anyway, but I think, ultimately, in stage three, what I think the consumer community talked a lot about is that what this looks like is actually I've got a blue button. I've got my comprehensive information in one place, and I've got automated links that contextualize the information so that I can understand it, places I can go to learn more about it. It's more of almost a health coaching that … provides, so that's ultimately where I think we're going, not necessarily I'm going to leave with ten brochures on my latest conditions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. I think it's how you interpret it. The denominator can be pretty broad, and then so if you have somebody with hypertension, the fact that you have it linked in the online experience, that qualifies. I don't know how to deal with the folks that don't want to have an online connection with you because then you'd be forced to print stuff, and that may not be wanted—that's the problem—on the 15th visit for hypertension.

Christine Bechtel – National Partnership for Women & Families – VP
Right. No, I understand the problem we're trying to solve.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But 10% of the denominator is everyone.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. I wonder, 80% seems unrealistic because we're really talking about chronic disease management ….

Christine Bechtel – National Partnership for Women & Families – VP
I see, so you'd go with the lower ….

Neil Calman – Institute for Family Health – President & Cofounder
What if we switched it from each visit to for each condition, so that if somebody had hypertension, you'd only have to give them that one time?

Christine Bechtel – National Partnership for Women & Families – VP
And it's not 100% threshold, so you have some further flexibility.

Neil Calman – Institute for Family Health – President & Cofounder
Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Anyway, 80% seems way too high. It might even be close to 20% or 30% because most visits are repeats.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think that's again go back to the quality measures side ….

David Lansky – Pacific Business Group on Health – President & CEO
There's a patient experience measure, which is whether the people … condition … involved, etc., and if people are doing well on those measures and hopefully this is being done.

Art Davidson – Public Health Informatics at Denver Public Health – Director
What about if we looked at highly prevalent conditions and say that, in their clinical summary, there is a link to this patient specific information about that highly prevalent condition, and you have to enable that. It's not about how many times you gave it out. It's not about whether you gave it out once or 100 times for hypertension. It's about you've made it available, and it's embedded. If we're really following what Christine is saying here is there's some electronic method by which you can access this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Except for the paper part though.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Pardon?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Except for the paper ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. We'll have to figure out how to do that, but I think, if we're going down this line of it's electronically available to the patient, does it need to be a separate thing, or is it just embedded in the clinical summary?

David Lansky – Pacific Business Group on Health – President & CEO
Again, I think if we ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Discharge instructions … educational materials, whatever.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Wherever. Yes.

David Lansky – Pacific Business Group on Health – President & CEO
The numeric threshold is relatively low. It means they've got the capability, and they can show it for a good number of people. Then the outcome measure is a better way to tell whether they're feeding people what is need, because there's always a problem with a process measure like this that the provider gives people boilerplate junk that they don't ever use. So we also have to test whether it's a meaningful use of information, not just that it's ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's why we put in the patient specific to avoid the copy of the CHS instructions on the back form of the discharge instructions.

David Lansky – Pacific Business Group on Health – President & CEO
Does anyone know if there's literature on the results of the pharmacy inserts, medication inserts, which are now ubiquitous …? Is there data on whether they're used effective and official? Somebody must know.

Josh Seidman – ONC
I'm sure there's data.

Deven McGraw – Center for Democracy & Technology – Director
Yes, there probably is data. I can try to find out because I've recently been in a lot of discussions with those folks in trying to prepare our comments to the marketing provisions of the HIPAA rule for which the inserts are a piece of that.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. That would help inform our thinking about this in terms of….

Josh Seidman – ONC
There's work going on, on that, from the IOM roundtable in health literacy. One of their sorts of focus areas is those inserts.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. Those are also driven by FDA requirements on what needs to be….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, I was going to say, it's required.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I can't help but think that CMS must be smiling thinking because we had this one … we should have to deal with this. All right. I think that wraps it up for some of the—

Christine Bechtel – National Partnership for Women & Families – VP
So we're going to come back on this pending more data? Is that how we're wrapping this up?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right now, we have it as a placeholder, a low threshold concerning the whole population. I think we said 30%, if you want to go back to that, or 20%.

Christine Bechtel – National Partnership for Women & Families – VP
I'll just flag that I think we want to spend—it makes me a little nervous as a consumer rep that we have very little decisions for stage two in this bucket compared to the others. So if we can just flag that we need some serious time on our next call for this particular category, that would be great. We'll do some offline work ahead of time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great. Thank you. Did you want to deal with the other recommendations in this domain?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next one, which is coming from our hearing, is this whole longitudinal, all hands on deck kind of a care plan that's shared.

Christine Bechtel – National Partnership for Women & Families – VP
Where are you?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Where are you?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's at the bottom of that page for the— No. I'm sorry.

Christine Bechtel – National Partnership for Women & Families – VP
No. We're at patient provider secure messaging.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Got it. Sorry.

Deven McGraw – Center for Democracy & Technology – Director
Forty-six.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that was in our— Yes. That was in our stage two placeholder as well. That was reinforced by the public hearing. Let's think it stage three again first. That means we want to have it in place, and I wonder if it is—are we measuring? This is an offer. You can't or shouldn't force people to use it, but you need to make it available. Is that the measure, the 90% offered?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's for the EP and/or hospital …?

Deven McGraw – Center for Democracy & Technology – Director
Yes. I forgot to ask that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I would like it to be for both, but ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And where does the information exchange thing fit in?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Information exchange, right?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think the hospital is a bit tricky on this one.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Who are you messaging with, with the hospital, patient services or …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, one way to look at this is you have this service available while you're in the hospital. You may want to make – instead of making … both the family and the patient, making sure they're awake when the attending comes in, questions come up. Wouldn't there be a nice way, a good way to even tee it up for when the attending visits you. Why not?

Neil Calman – Institute for Family Health – President & Cofounder
Yes. That's the ….

Christine Bechtel – National Partnership for Women & Families – VP
I'm confused. I had this visual of the hospital offering patient's PCs while they're lying in the bed. What are we talking about here?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We're actually doing that ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's actually done, and you can imagine without ….

David Lansky – Pacific Business Group on Health – President & CEO
Certainly with a phone.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, a phone or something like an iPad.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…family if the patient can't handle it, but we're actually using iPads for it.

Neil Calman – Institute for Family Health – President & Cofounder
In a lot of cases, it might be a family member outside the hospital.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. I'm not opposed to it. I'm just like, it's been a long time since I've been in the hospital apparently.

Deven McGraw – Center for Democracy & Technology – Director
It's a good thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are we at 90% and then so in stage two, we're just ….

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…patient messaging, even though in these prototypes we have it, I don't think we're getting there by 2015 across the nation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So it's a goal, but I don't know if it's 2015 goal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

David Lansky – Pacific Business Group on Health – President & CEO
I think we want to be not too prescriptive, but to have the capability generally embedded would be great.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Just enable it at this point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Stage two, enable it?

Art Davidson – Public Health Informatics at Denver Public Health – Director
To have some method for secure messaging.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So you do have to make X percent, and it doesn't have to be a defined percent, but it can't be the service is on, but nobody is home.

Christine Bechtel – National Partnership for Women & Families – VP
I agree.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's just … that it was there.

Christine Bechtel – National Partnership for Women & Families – VP
No, but I think … Paul's saying that that's not the right approach. So maybe it's you're offering it to 20% of your patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, we have a measure, not only how many percent of the patients have enrolled, but how many of the physicians, and hopefully that's 100% are on the receiving end.

Christine Bechtel – National Partnership for Women & Families – VP
Meaningful use is paid by to the individual providers, right, so it would be anybody who is a meaningful user, you would. You would capture that, but the ideal measure is really the percent of patients who are taking advantage of it, and so that we would say 5% of your patients are actually using it. Is it, I think, in some ways a better measure than you're offering it to 10% or 20% of your patients.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
As you think about the hospital, you've got really sick patients. They're not going to be using it, but it'd be their family members.

Christine Bechtel – National Partnership for Women & Families – VP
…EP.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We'll never be able to measure that in terms of ….

Christine Bechtel – National Partnership for Women & Families – VP
Let's do EP first, and then we'll ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I can deal with that.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
EP, are we saying it is a condition of getting the incentive is that you have that enabled and are receiving messages or no, and sending messages and responding to messages?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Are you back to offers?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a tall order.

Art Davidson – Public Health Informatics at Denver Public Health – Director
How about enable and percent using, percent of patients that are using this? If it's at zero, at least if you turned it on, it doesn't mean your patients may not want to use it. We know that we're headed farther down the path in 2015 to a real number. We're expecting to get to a point where there will be people using it, but this is a big first step to secure messaging.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It is a big first step; I have to tell you.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's a big first step.

David Lansky – Pacific Business Group on Health – President & CEO
It seems like a low threshold of use, even at 5% or 10% would be good so that it's not ….

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
…certification element, but it's actually something that works.

Christine Bechtel – National Partnership for Women & Families – VP
Right. I agree. It should be not zero.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
…un-reimbursed care … I don't know how much ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Messaging. Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now this is complicated. Primary care is different from specialty care.

Christine Bechtel – National Partnership for Women & Families – VP
What if we go with the 10%? You've offered it to at least 10% of your patients or 5% of your patients are using it, but it's a very low threshold.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Using what? To message with the doctor, 5% is a big number, a huge number. Let's think this through. Is offering it the whole testing thing, is that good enough for stage two? What that's saying is it's certifying that your EHR product allows this to happen.

Neil Calman – Institute for Family Health – President & Cofounder
And that you've implemented that functionality.

Christine Bechtel – National Partnership for Women & Families – VP
Not necessarily, Neil, not if it's just you've implemented it. You may not be using it, but your system can do it, but what good is that?

David Lansky – Pacific Business Group on Health – President & CEO
And that's particularly where there are quite a few physicians who counsel their patients not to contact them by e-mail, so you could have it as certified and available, but actively not using it.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

David Lansky – Pacific Business Group on Health – President & CEO
Which would not be the signal ….

Christine Bechtel – National Partnership for Women & Families – VP
And what is the point of asking them to go through the work if nobody is going to use it? I'd rather see, even a low threshold of your offering this service to whatever percent of your patients, but you're not accountable for whether they're using it or not, but you're at least making an offer.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Discuss that ….

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Offer to what percent?

David Lansky – Pacific Business Group on Health – President & CEO
Is this a test that you're doing now?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't know how you test. I don't know how you do that.

David Lansky – Pacific Business Group on Health – President & CEO
…high number. That surprised me.

Christine Bechtel – National Partnership for Women & Families – VP
No. He said 5% of patients using it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…high number.

Christine Bechtel – National Partnership for Women & Families – VP
And all I'm saying is if that's too much, then why don't we just say you're offering the service or communicating to 10% or 20% of your patients that it's now available.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In our comments ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But how do you offer it without using it, right?

Christine Bechtel – National Partnership for Women & Families – VP
That's the point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's part of the implicit point, yes. You'd have to be willing to answer the phone. We have to think further on how we assess this, how we measure these ~~o~~ffers".

Art Davidson – Public Health Informatics at Denver Public Health – Director
Or the low level of use ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Forty-seven is the recording of communication preference. That's one to get it certified to get it into the product, and the two to do something with it. We already have done something with it in the sense in other functions.

Tony Trenkle – CMS – Director of OESS
We said other functions are done in accordance with patient preferences. We haven't indicated how that is, whether it's captured or how it's captured.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, so this gets it into the product and gets us to use it, so it's basically record patient preference, and then … some threshold.

David Lansky – Pacific Business Group on Health – President & CEO
It should be comparable to some of the demographics we talked about earlier that we're capturing—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Fifty percent.

David Lansky – Pacific Business Group on Health – President & CEO
—a great majority of patients.

Christine Bechtel – National Partnership for Women & Families – VP
Do we have standards for how you want me to communicate with you on paper versus e-mail? What we originally listed in this category was preferred communication media, advanced directive, which we already cover, healthcare proxies, and treatment options, which is, I guess, around shared decision-making. That's parenthetically what it says as well. I'm looking at the original matrix that we did, which our spreadsheet here has been shorthanded. When we said report patient preferences in 2013 at that time, we said EG, preferred communication media, advanced directive, healthcare proxies, treatment options.

David Lansky – Pacific Business Group on Health – President & CEO
Good idea.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, it's a great idea.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's a good idea that we've since learned that you can't boil the ocean.

Christine Bechtel – National Partnership for Women & Families – VP
Right, so we've already handled advanced directives. I would probably say that as a byproduct of, assuming they stay in there, reminders, discharge summary, after visit summary, they probably are going to have to capture communication preferences because we say per patient preference. That would leave healthcare proxies and treatment options. Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you know what's more meaningful to do? Right now you signed up. You're on paper. When electronic media become available, you then allow. You then capture that. Just like in banking, etc., do you want to get paperless statements? That's the appropriate time.

David Lansky – Pacific Business Group on Health – President & CEO
These patient preferences are actually, for example, treatment preferences, not just communications preferences.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
They are?

David Lansky – Pacific Business Group on Health – President & CEO
The question is whether the provider is actively learning and that's what you talked about with the advanced directives, having a conversation about some of these issues and then capturing in the record.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a lot of stuff.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That was not.

Christine Bechtel – National Partnership for Women & Families – VP
It is and I think it's a hugely important area that we at least take a look at. We're obviously not prepared to do that today. But, David, we've talked about some measures of decision quality, for example, that might necessitate certain functionalities, so I'm not sure that this is something we should kick to the quality measure workgroup and ask for me on or if we should, in our next call, try to maybe ask Josh and the fabulous team to give us some more sense of what's out there and how are people capturing treatment preferences now through some of the informed decision making initiatives. I think it's worth us looking at because it would be hugely beneficial to patients. We would then need to develop a glide path of that. I don't think anybody is suggesting that we de facto come up with brand new everything and do this in 2013, but I think there's a glide path that's probably very important.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can we start with the communication preference because it drives other things?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we want it to get in the certification criteria.

David Lansky – Pacific Business Group on Health – President & CEO
And we already have the advanced directives addressed, so that gives us two wins.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You've got two pieces.

David Lansky – Pacific Business Group on Health – President & CEO
I think that makes sense to me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then we have the upload of patient generated, and the word ~~"u~~pload" was a trigger, but we want to be able to somehow allow patients to contribute information. And the second part, and it gets incorporated not only in the EHR, but somehow as part of the decision making. That's hard to enforce, but our goal is to find a way that is efficient for the provider as well. That's part of what's going on there.

Deven McGraw – Center for Democracy & Technology – Director
I really am very interested in trying to figure out a way to make this work. But I'm also mindful of the challenges being that this is not going to be one where one size is going to fit all. It's going to be incredibly variable based on what the needs of the patient are, as well as what the particular set of issues that the patient and the physician are working on together. But at the same time, I want to get something down from a meaningful use perspective so that we make sure that the systems are able to talk to one another, the systems used by patients, which are typically either PHRs or mobile health tools or devices, and then the systems used in the clinical setting.

That creates its own challenge because they're not the same tools. It's not like it's everybody using HealthVault or Google Health or the Carrot or some other PHR version. There's a lot of flexibility that's needed here, which makes the challenge even greater when part of what we're trying to do is make sure that the systems at least have that capability so that the patients, in working with their – the physicians and the patients working together can figure out what works best, given their mutual goals, so I'm really struggling with how we do this, but I really, really want to see if we can find a way to cut through this. Josh, I don't know if you've given this some more thought.

Josh Seidman – ONC
I'd just say there are two types of patient generated data that I think we're talking about here. The one around patient reported data is probably going to be dealt with to a certain extent in the quality measures workgroup where there is going to be a methodologic tiger team around that issue of incorporating patient reported data. That may be more on the quality measures domain. The other is the devices, the biometric monitoring and so forth, which could be very valuable for all kinds of clinical reasons, which is really a separate issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think what I heard you say, Deven and Josh, is that we want to make sure that we drive the standards and their implementations so that things can even connect, like devices, let's say. As a consequence, we'd want EHRs to be able to incorporate those things as soon as they can. On the other hand, this area of what data is important, how do you get meaningful data uploaded, and how do you meaningfully incorporate that into the provider's decision, that's the substantive research. It really is nowhere close to being— I mean, it's literally emerging research. So it would be very unwise for us to prescribe anything, which I think is what you're saying, Deven.

Somehow we want to, and this is part of our parking lot thing, drive the standards. There are standards evolving, and they continue up, for example, for the devices. We want to accelerate, drive and accelerate that standards activity and make sure the vendors incorporate those, but without saying this is what you do with this when we don't really know how yet.

Christine Bechtel – National Partnership for Women & Families – VP
Maybe what we do is have a signal for 2015 that there will be something around device connectivity.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Patient generated data.

Deven McGraw – Center for Democracy & Technology – Director
Yes, not device. I don't want to focus just on devices.

Christine Bechtel – National Partnership for Women & Families – VP
I'm not sure. In the second piece, which was really the first piece of what Josh talked about, that's how I look at it as well. What we heard from in the patient family engagement hearing was that in practice today there are successful examples of people doing functional status and mental health assessments online and incorporating that data. I think that's something that's appropriate for the quality measures workgroup to think about for stage two as a strategy for getting providers to begin to be accustom to accepting patient generated data, even if it's off a survey form, and then moving toward more device and other types of connectivity in the future. Where I think folks are saying it doesn't sound like we're ready for 2013, but we need to drive progress in that area by 2015.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That may be a fair way to go, so probably patient generated, patient entered data, it may be possible to do in 2013, but device entered data in the standarized, usable way, it may be a bit further off. But we want to signal and….

David Lansky – Pacific Business Group on Health – President & CEO
…in some cases the opposite ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think it's the opposite too because we don't know what the standards are around that patient entered data.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. I think either could move quickly or slowly, and it's going to be by conditions. The diabetes home monitoring or hypertension monitoring you could do tomorrow with a lot of the standardized devices where they've continued, and others have published standards. Something that's a wide open functional status report might take a lot longer … something simple, which is a patient self report of a symptom level or something could be done … little button gadget. There's a whole range of things. We all have a shared interest in encouraging more patient engagement by use of these technologies to the home or the phone.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One of the things that Christine said, we want the healthcare professional to get used to getting electronic data that's generated outside of the office and hospital. That's sort of the goal, and how do we achieve that? We could achieve it by just talking about patient generated data and getting EG directly entered or device. And maybe that's one way to start moving the ball because the standards committee can take that and start moving, driving those standards, and then not getting very specific until 2015.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
As I've listened to the conversation, it strikes me that you're evolving to a strategy, which builds out across EPs and ultimately hospitals, an infrastructure for patient engagement. It includes the provision of a secure portal or mechanism to exchange data to provide access, to provide download, to do secure messaging, to do e-mail, and ultimately support capture of data. If we can get those, you could start to picture this system in your mind because we're talking about the elements. Even secure messaging, and we struggled with that as a start to patient data, so there's a continuum.

Then, as the standards emerge, because you're going to want to—I want to upload something. It needs to be upload data from my PHR. It needs to be in a standard form, so the more we can drive toward those elemental pieces, I think, and then you can imbed it into clinical decision support or at least look at it. It seems like there should be a glide path.

Christine Bechtel – National Partnership for Women & Families – VP
I agree. But I'm thinking about, we have, at least in the data collecting, not … related, but functional status and experience, we have standardized tools absolutely done today.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We do.

Christine Bechtel – National Partnership for Women & Families – VP
We have electronic means through secure messaging or e-mail through patient portals. Yet those are the ways. We've just struggled to assess should we include patient education resources if we can instead ask a question about how well do you understand your condition, which would be driving that functionality. You can't do that without things like patient experience or functional status. And yet, we have the tools at our disposal to do that, and we don't have, which is where I really want to go in the long term.

What we don't have is the next step beyond that, which is the ability to take, for example, patient experience data that is structured, and roll it back into decision support so that when I show up, and I've answered an experience here that says I don't understand my condition, or I don't think you're doing a good job talking with my other doctors, the doctor gets an alert box that said there may be an opportunity here for a different kind of education resource, or there's an opportunity to work with her caregivers. That's where I think we should go. That's clearly not where we're at now, but we have all the ways to get

physicians and other providers accustomed to looking at experience and functional status and health status in tech enabled ways.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How about this? This is sort of like the CDS approach we used, which is the EG list. If the objective in stage two is to provide a mechanism to incorporate structured data from the patient, something like that, then you're getting to the structure. But we give the EG, which could be a structured questionnaire. It could be device interfaces. What it's doing then is it's wrapping into the standards committee and starting to drive that process even though we're not real prescriptive on what it is you do in stage two because of the nature of the ….

Christine Bechtel – National Partnership for Women & Families – VP
Right, and when they do some flexibility of what they could do ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct, and then we work a bit more on stage three, possibly after waiting to see what happens, as the field evolves. Does that feel comfortable?

Deven McGraw – Center for Democracy & Technology – Director
It does for now, although I think the kinds of data that comes off of survey was not exactly what I was thinking about.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
When we say survey, it could be … 12, for example, standardized things. It could be a pain measure.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're not talking about how you feel.

Deven McGraw – Center for Democracy & Technology – Director
That makes sense. Yes, I think we should put that down. I think when we get to the care coordination and care team discussion where we want the patient to have more of a role in that, I think we can think about this aspect of it in that context as well. That may actually be ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. Are you following your care plan?

Deven McGraw – Center for Democracy & Technology – Director
Right. Are you following your care plan, or what piece of the care plan is yours? Not that we have meaningful use for patients. That's for the payers to figure out.

Christine Bechtel – National Partnership for Women & Families – VP
…owning a piece of the care plan first if there isn't even a care plan to begin with.

Deven McGraw – Center for Democracy & Technology – Director
That's right. But to the extent that much of the testimony that we had in the care coordination hearing, we had providers testifying that even for them, for many of these chronic conditions where lifestyle is a huge issue, the patient has a big role.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
George, I think, in stage two, the starting words could be something like provide mechanism for patient generated data, e.g. structured questionnaire, comma ….

Christine Bechtel – National Partnership for Women & Families – VP

Or incorporating generated ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Device? No, I mean, they'll get more ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Device ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
…some pushback on, but I think at least a framework.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. This is a signal the standards committee needs in order to …. Then we'll figure out what to do with stage three once we get some experience. What is the next one?

David Lansky – Pacific Business Group on Health – President & CEO
…care management.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is not only we're trying to get patients access to their data. We're trying to provide them access with connectivity with their healthcare team. Now we're also, at least this is what we thought at the time, trying to get them electronic tools to help them. A tool can be as simple as tracking your weight or tracking your glucose. There's no threshold there. That may be too vague to actually reduce down to a reg, so that's the caveat there. If we do the other things correctly, get the data out, get it structured, get it in a standardized form, the market will develop these things. That's another way to look at this.

Deven McGraw – Center for Democracy & Technology – Director
I think one thing that we could do, if we don't know, if anything, we want to do in stage two is leave the signal in for stage three and ask people in the RFI. Should we, can we, and if so, what do anything in two.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It links into your care plan piece. This transcends that piece too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we want to put out the public infrastructure and give it a kick-start, but we don't have to finish the job. That's what we have the private sector to do.

Deven McGraw – Center for Democracy & Technology – Director
There are two other things, I think, before we go to the next category that I heard in the patient family engagement hearing that I don't see on the list, so just to flag them, and one was e-visits, and the other was online appointment scheduling.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's take those. Maybe we can craft that line 46, the secure patient messaging. Maybe we can incorporate e-visit in there. Now one way that can be done, the current … coding, which is, as you know, the standard way we code things for billing, allows for e-visits in a sense. For an established patient, so there are three categories of things we have to document: the history, the physical, and the medical decision-making. For an established patient, you can report on two out of those three to qualify. Obviously what you'd take away is the physical. Yes, you can do some things remotely. You can actually use today's ENIM coding system that CMS and the private insurance knows how to do and knows how to audit, and docs know how to code and still get credit for this.

For the secure patient messages that meet the ENIM coding, you could qualify … e-visit. See how that works? That would be a bit parsimonious. We could say something like incorporating, including

-qualified" e-visits when meeting ENIM coding criteria, something like that, just as a reminder of what we meant. Your other one was?

Christine Bechtel – National Partnership for Women & Families – VP
Online equipment scheduling.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That goes back to the clinical versus administrative.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. That's a good question. I don't know. Charlene, is it part of the PM system, or is it part of an EHR?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's usually the practice management system.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
And the PM systems don't have to be certified. Now there's some linkage that eventually they do or no? I can't remember.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
No.

Deven McGraw – Center for Democracy & Technology – Director
No.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
No. And even I think they're starting to clarify that feeds the demographic data they don't have to be.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The demographic, as long as it goes in the EHR. Now what about there was another example of reminders, which may be generated from the PM system?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't know that answer. These answers have literally just come out last night.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Does that do it? All right. We are 40 minutes left in this session, and do you want to go to care coordination of public health?

Christine Bechtel – National Partnership for Women & Families – VP
Care coordination.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Care coordination is the next one, and the first one is right now we're at the—well, this is the chicken and egg. We're mostly at tests at this point.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, I'm going to have to leave, so we'll probably pick up public health on the call.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sure.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Perform … HIE, we're sort of just waiting for HIEs to develop and mature. It's a little open question whether 2013 will be the magic inflection point. But our goal goes back to ….

Christine Bechtel – National Partnership for Women & Families – VP
This is not necessarily all caps HIE, right? This is the ability. What's in there now is the a single test of your ability to send data. We don't care if it happens through an HIE or not, which I think is wildly below the threshold.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The current state is in is that I can test that I can export a standard, CCD or CCR. But there's not a capability to require you in current state to import it. So it's going to be important that that comes up, right, so that you can receive it, right? But the feedback is that we need to build this out in stage two with … so the end game, and I'm not sure what disclosures means there in terms of stage three. But it is the exchange, the sending and receiving of relevant health information, the standard health information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, for stage one, you can do a vendor. It's peer-to-peer, and it can be vendor-to-vendor to different organizations. That exchange qualifies.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Actually, I have … before I can do it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. You're saying in stage three, what we want to do, even though it's listed as perform … we want to execute HIE. That is, exchange data that meets the interoperability standards amongst ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Whomever, right? Does HIE have to be in there? We would like it to be, but it could be provider-to-provider.

Deven McGraw – Center for Democracy & Technology – Director
Yes. I'm wondering if we go— I mean this is care coordination, right? So if we have really focus on other members of the care team and not just sort of like anybody, I don't know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think you're right. But it is wherever the patient data needs to go, this goes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Including the patient, right?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, but not in this bucket because that bucket, I think that'll be covered in page ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Stage three, we would want to have information flowing electronically, compatible or compliant with the interoperability standard … and is that 80%? Yes. There's always something that's going to escape the system.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we can't 100%. Why did I use 80% versus 90%? It's because there's a big space out there, I guess. I mean, you can have … there's all kinds of stuff that exists out there.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I have a question here since Charlene brought this up about from provider-to-provider. Is peer-to-peer exchange going to be sufficient here?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Not in stage three. In stage one, just a test of peer-to-peer exchange.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right, but I thought I heard you say, Charlene, that there could be from one provider to the next without a need for an HIE in the middle.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It would strike me we want that situation, as well as if an HIE is in town, you could do that. I guess I don't have confidence we're going to have all the HIEs built out by 2015.

Deven McGraw – Center for Democracy & Technology – Director
The outcome should be exchange happens.

David Lansky – Pacific Business Group on Health – President & CEO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right.

Deven McGraw – Center for Democracy & Technology – Director
It either happens directly, or it happens through the use of an HIE.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
…provider.

Deven McGraw – Center for Democracy & Technology – Director
I don't think we should have a measure ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm totally with that.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The data just has to get there in a usable way. How it gets there is something that the ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Whatever the infrastructure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then is the stage two just some smaller number?

Christine Bechtel – National Partnership for Women & Families – VP
Where are we at with NHIN Direct? I thought that was our savior for meaningful use stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For stage one, no, for stage one.

Christine Bechtel – National Partnership for Women & Families – VP
Stage one is a test. You don't even have to successfully ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
What we thought we were building out … stage two.

Christine Bechtel – National Partnership for Women & Families – VP
I'm sorry, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The assumption was NHIN Direct would give us a platform for stage two.

Christine Bechtel – National Partnership for Women & Families – VP
Right, so do we know, Josh?

Josh Seidman – ONC
Know what?

Christine Bechtel – National Partnership for Women & Families – VP
Where we're at with NHIN Direct?

Josh Seidman – ONC
I don't ….

Deven McGraw – Center for Democracy & Technology – Director
I mean, we should ask Arien, but I think that they're moving to pilots this fall, pilot testing this fall or maybe late this fall, and it's all largely a voluntary effort, so we'll sort of see what happens. But I think we should assume that—let's assume it works.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay ….

Deven McGraw – Center for Democracy & Technology – Director
I don't know. That's sort of a silly thing to do, but I think if we're staging up to 80%, we should—I guess the tendency would be to pick something around the middle. But the fact of the matter is that once this works, we won't need a staged threshold ideally, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
People still have to get on it, so I almost argue for a low threshold because it's getting it to work, which it's not how much really.

Deven McGraw – Center for Democracy & Technology – Director
And you might be able to get it to work with sort of a group of clinical trading partners that you work with, but not necessarily everyone.

Christine Bechtel – National Partnership for Women & Families – VP
Actually that's where I'm struggling with the directional nature of this statement requested disclosures because our universe is meaningful users. To me, I feel like it's going in the wrong direction, that it ought to be the meaningful user is proactively initiating exchange rather than the meaningful user is relying on a request for exchange to come in to be able to meet that. I guess I would almost think about this more

from the perspective of the shared care plan that the care plan is transmitted to all the members of the care team. That it is much more a proactive transmission than reactive.

David Lansky – Pacific Business Group on Health – President & CEO
The summary of care transmission I thought was where the real power of this set of recommendations lay, which is the next two down, 54. And maybe we should talk back through a little bit and see if it gets us farther down the road that makes the other one easier.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Or maybe irrelevant.

Christine Bechtel – National Partnership for Women & Families – VP
That's a good point. Right. That's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So there might be a stage two to get us kicked off, but really it's the transference of care records.

David Lansky – Pacific Business Group on Health – President & CEO
…whether the recipient is capable of getting it electronically across any exchange platform that we have versus I'm pushing a PDF out or mailing it. All the HIE work, I think, is to address row 54, in effect.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's try 54. The draft says summary care record provided electronically for 80% of transitions of care and referrals. That was the objective. That 80% of those things are conducted electronically.

David Lansky – Pacific Business Group on Health – President & CEO
But provider, it seems like e-prescribing. By provided, you mean both to closed system, both ends are handling electronically, or the receiver is just …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The provider who is trying to qualify for the meaningful use can only do what the provider, is only … what they do ….

David Lansky – Pacific Business Group on Health – President & CEO
Their partners are not enabled to receive it electronically. I can … my incentive payment by pushing out electronically a signal even though it's bouncing around ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You want it provided and received.

David Lansky – Pacific Business Group on Health – President & CEO
You can't control that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You can't charge the EP with that responsibility.

David Lansky – Pacific Business Group on Health – President & CEO
If I'm in a poor … area, I might ….

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right … problem.

David Lansky – Pacific Business Group on Health – President & CEO
…partners who can do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Instead of provided, it's made available?

Deven McGraw – Center for Democracy & Technology – Director
Operationalize … made available ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
We're not interested in what happens on the receiving end, how it gets incorporated into the EHR?

Deven McGraw – Center for Democracy & Technology – Director
No, I think we are.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
We're just trying to figure out, can we hold the sender responsible for what the recipient does.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, we can't.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The last time we left a lot of exercise to the readers for CMS, and we're just trying to be a little nicer this time around.

David Lansky – Pacific Business Group on Health – President & CEO
At a minimum, we do want the EP to be transmitting or capable of transmitting this as an electronic document.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
And we want the EP who are recipients to be receiving….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Provide summary of care. Actually, provided could accommodate what you just said because you made it available and can transmit it, and that's what you do to earn your share. Now then we might have an accompanying is—that's interesting. Receives summary care records electronically.

Art Davidson – Public Health Informatics at Denver Public Health – Director
It's almost like performing a summary of care record reconciliation. Somehow they're accepting the history that's being provided to them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wait a minute. Actually, it does work. First of all, these are both menu items, right, which would become required in stage two. And, actually, in fact, this was done asymmetrically, but when you take the pair of them, it works. Provide is on the burden of the sender. The med rec is a burden of being able to receive and deal with. So it turns out when you use those as a pair, and it will be core by stage two, then it sort of implicitly gets you to exchange at least medications.

David Lansky – Pacific Business Group on Health – President & CEO
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then maybe we can change 52 to talk about your capability of handling health information exchanges electronically. That means you basically are receiving all of your health information documents electronically.

Deven McGraw – Center for Democracy & Technology – Director
The other thing that I would like to consider adding here is the notion of the shared care plan, which is different than the summary record.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's the next one, 57, actually.

Deven McGraw – Center for Democracy & Technology – Director
Sorry?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Does that make sense for 52? It's really external health information is exchanged electronically. Exchange is sort of a bidirectional thing. Then the next one is what Christine started out with is what we heard loud and clear. The longitudinal care plan is available for electronic exchange for some number of patients. It's basically available, so the end goal is that the longitudinal care plan is shared and available for everybody who needs it.

Deven McGraw – Center for Democracy & Technology – Director
Can George? There's a comment row missing, I think, somewhere? Yes. Perfect.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just scroll over to the right a little bit so we can read both of them. One more.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. Good.

Deven McGraw – Center for Democracy & Technology – Director
I think the only thing I struggle with here, I think it's close, is the same topic that we were discussing earlier, which is this to me says the functionality is there, but it may or may not be in use, and by 2015, it should be. In other words, it should be more than just available for exchange. It should actually be exchanged.

David Lansky – Pacific Business Group on Health – President & CEO
How much of an impact or expectation is this upon current clinical practice to have a longitudinal care plan in a form that could be exchanged? What proportion of EPs out there in the universe routinely have such a thing in hand now, and for what proportion of patients?

Deven McGraw – Center for Democracy & Technology – Director
A pretty small percent, I would imagine.

David Lansky – Pacific Business Group on Health – President & CEO
We're asking not just for an IT … we're asking for a clinical redesign.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Which is the core of meaningful use in my view.

Deven McGraw – Center for Democracy & Technology – Director
And to what extent? Now I'm going to reveal that I am not as steeped in the health reform legislation as I am in HITECH, and to what extent can some of what's happening with respect to accountable care organizations and medical homes be leveraged in this space so that there's a combination of those efforts?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's another good topic. In a sense, ideally we would be – somehow we have an inventory of the things we needed to support the reform agenda. Now accountable care organizations is one of those things, but it's just one of those things, and have them essentially deem each other. So if this is a super set, since all providers and hospitals are eligible for this, but not all providers in hospitals would do this, this, or this under the Affordable Care Act, then we would want to say, if we do this, then you're going to meet this particular criteria under ACO, let's say, with respect to certification. Do you see what I'm saying?

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We'd love to do that reconciliation and non-duplicative effort.

Christine Bechtel – National Partnership for Women & Families – VP
But don't you think, Paul, a care plan, a longitudinal care plan is really pretty much the cornerstone of ACO and medical home.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But that's what makes it then do it, not us saying this reg you have to do. You see what I'm saying? It's the pull rather than the push.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I understand that, although they are clearly. I mean, there was a meeting on, I think it was October 8th, around PCMH medical home, and they looked at HIT medical home. They looked at everything, and care coordination in particular. And this was a piece that they were really looking to meaningful use to begin to drive some improvement in. This was something that we heard about in … care coordination hearings that we needed. So I think we need a glide path to get there, but I think that's close to the right place to go.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But what they asked for is nowhere in the EHR products of today.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And by doing this, even doing this, we're going to start; we're going to move it into the EHR products.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what they wanted to do.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's not so much that we have to stand over the shoulders and force them to use it. They're going to use it because of whatever they're trying to do to coordinate the care that drives efficiency and effectiveness.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
There are a couple elements….

Christine Bechtel – National Partnership for Women & Families – VP
…like it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Our job is to get it in the systems because we have no way to do this right now.

Christine Bechtel – National Partnership for Women & Families – VP
You can't take that argument too far because we've just had this whole discussion about having functions available, but how do we insure that they're being used. It cuts both ways. Anyway, so what do we think for stage two, I think, is the question, right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This came back to there's experience in the field with care plans within venues, not so much across venues, and there's been some standards written, actually. I think this is the space we could look to actually—I know they've created a CCD. It's not formalized … captures the elements of those care plans. There are pieces of this out there. We don't know what that shared care plan looks like yet because we haven't built one yet, so that might evolve. It's hard. It gives me a little bit of … to look at saying having that in place by 2015, but clearly that's the goal. But there are some elements in place that clearly— I think it's one of those like that other one. We put the near term stuff and ask for some input for what that long-term looks like because there are elements in place that are in products today and/or in development that the standard is not ….

(Call ends abruptly.)

Public Comment Received During the Meeting

1. Will the spreadsheet you've been working on be made available to the public?

2. Are we not discussing Public health today?

3. Ahhh - a working document that I can watch them create live! This is government as a platform for innovation...